Discharge Handoff Communications 2008 Field Book

CRITICAL SUCCESS FACTORS

- Establish Open, Two-Way Communications
- Define Responsibility and Accountability
- Implement Quality Assurance Practices
- Conduct Ongoing Education and Training
For more information about the Discharge Handoff Communications 2008 Benchmarking Project, contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu.
Excellence in health care requires safe, effective, high-quality care across the continuum. To achieve excellence, organizations must ensure that accurate and comprehensive communication occurs as the patient moves from one health care provider to another. The discharge handoff following an inpatient admission is one example of a critical transition point for the patient.

Errors in the discharge handoff communication process are associated with adverse outcomes. Health-related outcomes include incorrect or delayed diagnoses and treatments and life-threatening adverse events. These outcomes can reduce patient satisfaction, generate patient complaints, and increase health care expenditures by resulting in avoidable readmissions and emergency department visits and longer hospital stays. Additional drivers for effective discharge handoff communications include issues affecting quality, safety, service, and operations.
Executive Summary

Regulatory deficiencies may result if the discharge handoff communication process does not go smoothly. The Joint Commission has recognized the importance of effective handoff communications and has outlined specific attributes that promote accurate and appropriate handoff communications:

- Handoffs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient/client/resident information.
- Handoffs include up-to-date information regarding the patient’s/client’s/resident’s care, treatment, services, condition, and any recent or anticipated changes.
- Interruptions during handoffs are limited to minimize the possibility that information will fail to be conveyed or will be forgotten.
- Handoffs require verification of the received information, including repeat-back or read-back, as appropriate.
- The receiver of the handoff information has an opportunity to review relevant patient historical data, which may include previous care, treatment, and services, as well as to request clarification of that information.

Improvement of discharge handoff processes can be hampered by a lack of organizational buy-in and the absence of a focus on the importance of this communication. Physician and staff support is necessary for the success of any process improvement. Inconsistent practices within an organization can also impede improvement efforts. Even when policies are in place, staffing issues can interfere with implementation, and effective communication systems must be established so that even long-distance transfers are accompanied by essential patient information.

Project Background

UHC’s Transitioning Care 2007 Benchmarking Project identified significant opportunities for improving discharge handoff communications. Recognizing the impact that these handoffs can have on patient care, senior leaders of UHC member organizations and members of the UHC Ambulatory Care Council rated discharge handoff communications as a topic of great importance. The UHC Discharge Handoff Communications 2008 Benchmarking Project was undertaken to identify current practices at UHC member organizations, pinpoint areas of improvement, and provide performance data to support improvement initiatives.

The steering committee identified 4 key performance measures for this benchmarking project:

- Satisfaction scores from nonacute provider organizations
- Hospital discharge handoff communications self-assessment score
- Percentage of key handoff information present in an audit of discharge communications
- Bundled score for effective discharge handoff communication practices

Better-Performing Organizations

Project participants were evaluated on the performance measures, and 4 organizations were selected for follow-up interviews and identified as better performers:

- Harborview Medical Center.
- Massachusetts General Hospital
- University of Michigan Hospitals and Health Centers
- University of North Carolina Hospitals

In addition, representatives from 5 nonacute provider organizations—long-term care, subacute care, rehabilitation, ambulatory care, and home care—that receive discharged inpatients from participating hospitals were interviewed about their discharge handoff communication needs.
Key Take-aways

Project findings reveal that essential clinical information is not always included in discharge handoff communications. Analysis of the findings identified key take-aways:

• It is essential that organizations recognize and accept that they must establish two-way communications between acute and nonacute care settings to effectively understand and address information needs.
• A major gap exists in defining responsibility for managing and following up on patients during the discharge transition process. This issue must be resolved to ensure the safety and quality of care.
• Discharge communications for patients released from acute care facilities must be timely, accurate, and complete before hospitals can expect to receive high-quality admission information from organizations that transfer patients into acute care.
• All project participants, including better-performing organizations, have improvement opportunities related to their discharge handoff communication process.

Critical Success Factors

Analysis of project data and interviews with better-performing hospitals and nonacute provider organizations led to the identification of 4 critical success factors for achieving safe and effective discharge handoff communications.

Establish open, two-way communications. Communication is an essential component of ensuring that care is effective and patient safety is protected. Understanding the needs and capabilities of the receiving organization is crucial to developing systems that meet the needs of caregivers on both sides of the transfer and the needs of patients. The information must be easily accessible so that discrepancies and uncertainties about patient information can be quickly identified, clarified, and rectified.

Define responsibility and accountability. Identifying the individual responsible for managing the discharge of a patient and following up on patient-related data (including pending test results) and then holding that individual accountable for the transfer’s success are critical parts of an effective discharge handoff communication process.

Implement quality assurance practices. Policies and procedures alone do not ensure effective discharge handoff communications, although they are a necessary component of the improvement process. Routine checks of the information included in the discharge packet and surveys of internal and external customers are important measures of the effectiveness of handoff policies and procedures.

Conduct ongoing education and training. The discharge handoff communication process is encumbered with complex clinical issues and regulatory standards that require ongoing education of staff. Training efforts need to be geared to all practitioners who have a role in the discharge process, including the physician, the nonacute provider, patients and families, and other staff.
Executive Summary

The Next Step Is Yours

The UHC Discharge Handoff Communications 2008 Benchmarking Project provides valuable data and strategies for improving the postdischarge information your organization generates to assist nonacute providers in caring for patients.

Sharing this information with your administrative and clinical leaders and quality assurance teams will increase buy-in for process improvement. Buy-in, training, education, open communication, quality checks, and leadership support for assigning handoff responsibility and holding individuals accountable are the keys to achieving accurate and comprehensive discharge handoff communications.

UHC provides several resources to help you improve discharge communications, including the operational survey results, a collection of participants’ innovative strategies, and a Performance Opportunity Summary and Scorecard that has been customized for your organization and can help you identify improvement opportunities. The action plan is a workbook that can be customized to guide your change initiatives.

For more information about this project, contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu.

For More Information

To find these resources for the Discharge Handoff Communications 2008 Benchmarking Project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area. Resources available include:

• Knowledge transfer meeting presentations and Web conference recordings
• Results of acute care hospital survey, nonacute provider organization satisfaction survey, and nonacute provider organization audits of discharge packets
• Innovative strategies
• Action plan
• Sample Performance Opportunity Summary and Scorecard
• Handoff Communications listserver
• Information about the Discharge Handoff Communications 2008 Implementation Collaborative
• Materials created for the Transitioning Care 2007 Benchmarking Project
Study Profile

- 21 acute care academic medical center (AMC) facilities completed a hospital survey and self-assessment
- 61 nonacute provider organizations, reporting for 19 acute care AMC hospitals, responded to a survey of their satisfaction with discharge communications
- 51 nonacute provider organizations, reporting for 18 acute care AMC hospitals, audited 413 patient records to evaluate the discharge communications actually received
- 4 better-performing acute care AMC hospitals were interviewed to identify best practices
- 5 nonacute provider organizations were interviewed to learn about their discharge handoff communication needs (long-term care, subacute care, rehabilitation, ambulatory care, and home care facilities)
- Project participants submitted 41 innovative strategy reports describing discharge handoff-related improvements implemented by their organizations
Project Findings

Key Performance Measures
Wide variations in overall performance were identified when the key performance measures were evaluated (Figure 1). All organizations, including the better performers, had significant room for improvement in the discharge handoff communication process.

Discharge Handoff Communications Policies and Procedures
Project liaisons consulted with key stakeholders to respond to a survey and self-assessment about the discharge handoff communications of the acute care hospital. Twenty-one organizational responses were received.

Information included in the discharge packet.
Across participating organizations, the discharge packet routinely includes some information, such as the list of discharge medications (100% of the time) and the list of major diagnoses (95% of the time). Yet other crucial information is often missing from the discharge packet (e.g., the response to treatments for major diagnoses/procedures). See Figure 2.

Discharge summary completion. Project participants have differing goals for completing the final discharge summary, but 47% strive for completion at or within 24 hours of discharge (Figure 3). University of Michigan Hospitals and Health Centers has developed an electronic discharge navigation tool to assist caregivers in preparing and finalizing discharge and transfer communications and summaries.

Electronic medical record access. For 67% of project participants, discharges to nonacute providers not owned by the acute care facility are often more challenging than discharges to affiliated organizations, yet survey findings suggest that the presence of an electronic medical record is not a universal solution for effective discharge communications. Access to all or most of the inpatient electronic medical record is granted to nonacute provider organizations owned by the acute care facility in 81% of responding organizations. None of

Survey findings suggest that the presence of an electronic medical record is not a universal solution for effective discharge communications.

Key Performance Measure Scores

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean for All Participants</th>
<th>Mean for Better Performers</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average satisfaction scores from nonacute provider organizations (goal = 1.00)</td>
<td>0.06</td>
<td>0.25</td>
<td>-0.55 to 0.36</td>
</tr>
<tr>
<td>Hospital discharge handoff communication self-assessment score (goal = 1.00)</td>
<td>0.23</td>
<td>0.41</td>
<td>-0.46 to 0.77</td>
</tr>
<tr>
<td>Key handoff information present in audited discharge communications, % (goal = 100%)</td>
<td>75</td>
<td>93</td>
<td>11 to 95</td>
</tr>
<tr>
<td>Effective discharge handoff communication practices bundled score, % (goal = 100%)¹</td>
<td>48</td>
<td>61</td>
<td>0 to 71</td>
</tr>
</tbody>
</table>

Figure 1 – Source: Acute care hospital survey results

¹ Issues evaluated in the bundled score by means of the hospital survey:
- Discharge handoff improvement goals are formally aligned with organizational quality and safety goals.
- The hospital requires responsible discharging clinicians to communicate directly with the receiving provider before discharge.
- Hospital staff are designated to follow up and manage the patient’s care prior to the first ambulatory appointment.
- Hospital staff are designated to follow up regarding significant diagnostic test results pending at the time of discharge.
- The goal for completion of the final discharge summary is at the time of discharge.
- Discharge planning is initiated during preadmission or within 24 hours of admission.
- The medication reconciliation process is performed at the time of discharge.
### Key Information Included in the Discharge Packet (When Applicable)

<table>
<thead>
<tr>
<th>Information</th>
<th>Percentage of Responses Indicating Inclusion of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of discharge medications</td>
<td>100</td>
</tr>
<tr>
<td>List of major diagnoses</td>
<td>95</td>
</tr>
<tr>
<td>Description of the patient’s course during hospitalization</td>
<td>95</td>
</tr>
<tr>
<td>Relevant diagnostic test results</td>
<td>90</td>
</tr>
<tr>
<td>Follow-up plan</td>
<td>90</td>
</tr>
<tr>
<td>Discharging physician’s discharge or transfer note</td>
<td>90</td>
</tr>
<tr>
<td>Final discharge summary</td>
<td>90</td>
</tr>
<tr>
<td>Treatments rendered for major diagnoses/procedures</td>
<td>86</td>
</tr>
<tr>
<td>Information about drug allergies, intolerances, adverse drug reactions</td>
<td>86</td>
</tr>
<tr>
<td>Medical history</td>
<td>81</td>
</tr>
<tr>
<td>Resuscitation code status</td>
<td>76</td>
</tr>
<tr>
<td>Name and contact information for discharging physician</td>
<td>76</td>
</tr>
<tr>
<td>List of preadmission medications</td>
<td>71</td>
</tr>
<tr>
<td>Current physician orders</td>
<td>71</td>
</tr>
<tr>
<td>Response to treatments for major diagnoses/procedures</td>
<td>67</td>
</tr>
<tr>
<td>Information about pending test results and data</td>
<td>67</td>
</tr>
<tr>
<td>Discharging RN’s discharge or transfer note</td>
<td>57</td>
</tr>
<tr>
<td>Name and contact information for discharging RN or unit</td>
<td>52</td>
</tr>
<tr>
<td>Information about living will or power of attorney</td>
<td>52</td>
</tr>
<tr>
<td>Current and historical vaccination information</td>
<td>43</td>
</tr>
<tr>
<td>Surgeon’s preliminary operative note</td>
<td>38</td>
</tr>
<tr>
<td>Emphasis on safety issues and high-risk medications</td>
<td>29</td>
</tr>
<tr>
<td>Final operative note</td>
<td>24</td>
</tr>
</tbody>
</table>

*Figure 2 – Source: Acute care hospital survey results*

*RN = registered nurse.*

### Goals for Completion of Final Discharge Summary

- **Not Established**: 5%
- **Varies**: 10%
- **Within 30 Days**: 18%
- **Within 2 Weeks**: 5%
- **Within 1 Week**: 5%
- **Within 3 Days**: 10%
- **Within 24 Hours**: 18%
- **At Time of Discharge**: 29%

*Figure 3 – Source: Acute care hospital survey results*
the participants routinely allow full access to independent providers; 19% grant partial access. Two better-performing organizations, University of Michigan Hospitals and Health Centers and University of North Carolina Hospitals (UNC), grant full electronic medical record access to independent providers on a case-by-case basis.

Direct communication between caregivers. One-third of participants (33%) do not require direct communication between discharging and receiving clinicians, although National Patient Safety Goal (NPSG) requirement 2E states that organizations must implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions. Of the 67% that require direct communication, many said that this communication does not always happen or occurs only when patients are transferred to an extended-care facility and/or that there is no audit process in place to assess compliance with the requirement. Only 14% of participants routinely check with nonacute providers to ensure that discharge information was received and understood.

Oversight of discharge handoff communications. For slightly more than half of project participants (52%), no single group or committee is responsible for ensuring the quality of discharge handoff communications. Only 19% have such a group, while 29% reported that this responsibility is shared or varies within the organization.

Responsibility during the transition process. Responsibility for following up and managing the patient’s care during the transition to ambulatory care varies greatly or is nonexistent (Figure 4). At 42% of responding organizations, that responsibility varies or is undefined; 24% cede the responsibility to patients and families. At only 2 organizations, UNC and Rush University Medical Center, the inpatient discharging physician is responsible for the patient during the time between discharge and the first ambulatory appointment. Responsibility for follow-up on pending diagnostic test results also varies (Figure 5).

Patient and family communication and support. Survey findings suggest that communication with the patient and family is often lacking. While most organizations (81%) provide the patient with a list of major diagnoses, only two-thirds provide a list of procedures and treatments. Less than half (43%) offer the

Survey findings suggest that communication with the patient and family is often lacking.

Responsibility for Management and Follow-up After Discharge but Before the First Ambulatory Appointment

![Responsibility for Management and Follow-up After Discharge but Before the First Ambulatory Appointment](image)

*Figure 4 – Source: Acute care hospital survey results*
patient/family a copy of the discharge packet, and even fewer (33%) provide information about pending test results. Completed test results are given to the patient/family by 29% of responding organizations, and patient/family goals are routinely included in the discharge packet at only 19%. Ten percent of project participants provide the patient/family with online access to the patient’s personal health information.

Opportunities exist to improve support for patients and families during care transitions. Slightly less than half of responding organizations (48%) have implemented services (e.g., concierge, patient advocates, advisers) to support patients and families during transitions. Practices related to the release of medical information are consistent across the organization for only 29% of participants. And just 10% call patients and families after discharge to assess their understanding and compliance. However, 1 better-performing organization, Harborview Medical Center, included a patient adviser with other stakeholders in a 4-day retreat on improving discharge procedures and communications.

Organizational leadership. Almost one-third of responding organizations (29%) do not align discharge handoff initiatives with organization-wide goals (e.g., safety). However, Partners HealthCare System, Inc, has developed system-wide goals that include the safety and effectiveness of clinical transitions. Data are reported quarterly to each hospital board and to the Partners board and are publicly defended by the responsible individual.

Survey findings indicate that safe discharge practices are not always in place and mandated by organizational leaders. For example, medication reconciliation is always or almost always conducted at the time of discharge at 81% of organizations. Discharge planning is initiated during predmission or within 24 hours of admission at 67%.

Internal discharge handoff communication challenges. Several circumstances create the most challenging situations for discharge communication. Off-shifts (evenings, nights, and weekends) are challenging for 81% of participants. Almost two-thirds of participants (62%) struggle with changes in the resident rotation schedule. For 24%, attending physician verification of discharge orders and unavailability of case managers or social workers are each a significant challenge. Discharges to distant and/or out-of-state providers are the most challenging for one-fourth of project participants.

Organizational self-assessment. Results from the self-assessment in the acute care hospital survey identified significant improvement
opportunities (Figure 6). Just 10% of respondents agreed that “notification of pending data is routinely included in the discharge packet.” Only 29% agreed that their organization’s discharge handoff communications are consistent with The Joint Commission’s definition of effective communication: “timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved [patient] safety.”

**Quality assurance practices.** Establishing policies and procedures for discharge handoff communications does not guarantee that these mandates are followed. Quality assurance programs must be in place to ensure that effective discharge handoff communication occurs. Almost one-fifth of respondents (19%) do not currently use any quality assurance methodology to ensure compliance with policies and procedures.

Discharge handoff communication quality assurance practices vary among the participating organizations. Two-thirds (67%) review discharge information prior to discharge, and 62% gather patient/family satisfaction data on discharge and transfer practices. Only 29% survey nonacute provider organizations about their satisfaction. Manual audits of discharge packets are conducted after discharge by 19%; only 1 participating organization (Massachusetts General Hospital) audits the information actually received by the nonacute provider.

**Education and training.** Discharge handoff training opportunities for staff also vary among participating organizations. Almost two-thirds (62%) offer ongoing education for physicians and staff on discharge procedures, regulations, and safety issues. Check lists, templates, and tools to facilitate compliance with discharge procedures are used by 57%. UNC uses an electronic learning management system to train staff on discharge handoff policies and procedures.

One-third of participants (33%) conduct periodic supervisory observation of discharge and transfer practices to assess compliance and competence. Methods to ensure accountability of physicians and staff for compliance with discharge and transfer policies have been implemented in 29% of participating organizations. Only 10% use incentives, recognition, and rewards to promote compliance with discharge and transfer policies and procedures.

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**Acute Care Hospitals’ Self-Assessment of Discharge Handoff Communications**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage of Responses Agreeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of pending data is routinely available in the discharge packet</td>
<td>10</td>
</tr>
<tr>
<td>Patient/family goals are routinely included in the discharge packet</td>
<td>19</td>
</tr>
<tr>
<td>Nonacute providers are very satisfied with discharge information</td>
<td>29</td>
</tr>
<tr>
<td>Discharge information is timely, accurate, complete, unambiguous, understood, and designed for safety, quality, and to reduce error</td>
<td>29</td>
</tr>
<tr>
<td>Conflicting information is never/rarely found in the discharge packet</td>
<td>40</td>
</tr>
<tr>
<td>Doctors and staff have a good understanding of the discharge communication needs of nonacute care organizations and providers</td>
<td>48</td>
</tr>
<tr>
<td>It is easy to identify and contact the responsible discharging provider</td>
<td>52</td>
</tr>
<tr>
<td>Accurate, comprehensive preadmission and postdischarge medication lists are included</td>
<td>52</td>
</tr>
<tr>
<td>Discharge information is almost always consistent with regulatory standards</td>
<td>57</td>
</tr>
<tr>
<td>Essential clinical information is never/rarely missing</td>
<td>62</td>
</tr>
</tbody>
</table>

*Figure 6 – Source: Acute care hospital survey results*
Discharge Handoff Communication Perceptions

Nonacute provider organizations identified by the project liaisons submitted an organizational response about general satisfaction with the discharge/transfer communications received from the acute care AMC hospital. Sixty-one nonacute provider organizations for 19 acute care hospitals responded to this satisfaction survey. Figure 7 identifies the types of nonacute provider organizations.

A median of 28% of the patients seen each month by the nonacute organizations surveyed are newly discharged from an acute care AMC hospital (range, 1% to 65%). Data were analyzed by type of ownership (independent, 51%; owned by/affiliated with acute care facility, 49%) and by provider group (clinics and faculty/nonfaculty physician practices, 44%; long-term care, skilled nursing, rehabilitation, and subacute care facilities, 40%; and hospice and home care organizations, 16%), but this analysis did not reveal a significant variation by type of ownership or provider group.

Electronic access to patient information.
Electronic access to acute care hospital inpatient information is not available to 30% of responding nonacute facilities, but 28% have electronic access to all or almost all of the information. Selected information (e.g., test results) is available electronically to 28% of nonacute providers, while 11% have partial access to patient information but no access to physician or nursing notes. Integration with the hospital information system varies from none (67% of respondents) to partial (10%) to complete or almost complete (23%).

Postdischarge appointments. For almost half of nonacute participants (47%), their acute care facility schedules postdischarge appointments before the patient leaves the hospital, but patients do not always keep these appointments. These “no-shows” happen less than 11% percent of the time for 32% of nonacute participants, 11% to 25% of the time for 10% of nonacute participants, and 26% to 50% of the time for 13% of nonacute participants. Involving patients and families in the scheduling process before discharge has resulted in increased compliance with postdischarge appointments at UNC and Michigan.

Nonacute provider satisfaction. Satisfaction survey results show that many nonacute providers are dissatisfied with current discharge handoff communications (Figure 8). The highest obtainable satisfaction score was 1.00, but the mean score was 0.06 (range, -0.55 to 0.36). Only 34% of nonacute provider participants are “very satisfied with the discharge information received,” and just 39% agreed that “essential clinical information is never/rarely missing” from the discharge information received.

![Types of Nonacute Provider Organizations Reflected in Survey Responses](image)

Figure 7 – Source: Nonacute provider organization satisfaction survey results
Handoff needs of nonacute providers. Analysis of survey results and interviews with 5 nonacute provider organizations (long-term care, subacute care, rehabilitation, ambulatory care, and home care) provided insight into the needs of these important participants in the continuum of care. Accurate, timely, comprehensive, and consistent information is needed for patient safety and treatment continuity.

Information about patient/family concerns and preferences, including code status, pain management, end-of-life care, and family participation in care, is essential. Information on advance directives and health care insurance is also important. Critical clinical information about allergies and medical history, immunizations and tuberculosis status, infections and precautions, height and weight, preadmission and discharge medications, last-dose information, current care plan, and anticoagulation therapy specifics is beneficial and enables safe, appropriate, and seamless care for patients. Highlighting data that are pending lowers the probability that this information will fall through the cracks. Details about intravenous lines, catheters, and follow-up appointments should also be communicated.

Specific nonacute providers identified unique needs. Long-term care providers need to have discharge orders in advance so that they can appropriately prepare to receive the patient. Rehabilitation providers need accurate, qualifying diagnoses. Receiving the discharge packet prior to the first visit is important to ambulatory providers and clinics. Referring physicians require notification and updates about their patients’ admissions and status. One referring physician did not even know that his patient had undergone a heart transplant until he was informed by the patient during an office visit.

Discharge Handoff Communication Practices

Fifty-one nonacute providers for 18 acute care hospitals audited 413 records of patients recently discharged from acute care to evaluate the discharge information received. The audits showed that vital information is often missing from discharge communications (Figure 9). Preadmission medications were not included in 54% of the records reviewed, and information about drug allergies, intolerances, and adverse drug reactions was not available in one-third of the packets.
A significant percentage of discharge communications do not meet the needs of the nonacute provider. Impressions of the discharge packets audited were solicited. Only 78% of the information in the discharge packets was judged legible and easy to read. Sixty-nine percent of auditors agreed that important clinical information was easy to find in the discharge packet, and 64% agreed that the discharge packet included all of the pertinent clinical information necessary for the care of the patient. Seventy-one percent of auditors agreed that the information in the discharge packet was succinctly presented.

For More Information
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### Results of Audits of Information Included in Discharge Packets (When Applicable)

<table>
<thead>
<tr>
<th>Audit Question</th>
<th>Percentage of Responses Disagreeing(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission medications were included</td>
<td>54</td>
</tr>
<tr>
<td>Drug allergies, intolerances, or adverse drug reactions were included</td>
<td>33</td>
</tr>
<tr>
<td>Final discharge summary was present</td>
<td>30</td>
</tr>
<tr>
<td>Information about pending data was included</td>
<td>29</td>
</tr>
<tr>
<td>Response to treatments for major diagnoses/procedures was included</td>
<td>24</td>
</tr>
<tr>
<td>Adequate follow-up plan was included(^b)</td>
<td>24</td>
</tr>
<tr>
<td>Discharge medications were included</td>
<td>19</td>
</tr>
<tr>
<td>Treatments rendered for major diagnoses/procedures were included</td>
<td>15</td>
</tr>
<tr>
<td>Names of major diagnoses/procedures performed were included</td>
<td>13</td>
</tr>
<tr>
<td>You could locate the name of the discharging physician</td>
<td>12</td>
</tr>
</tbody>
</table>

\(^a\) Auditors responded only for the postdischarge information actually received from the acute care hospital, not for information obtained from the patient/family or through follow-up research and queries.

\(^b\) An adequate follow-up plan includes the name of the provider who will follow up, the approximate time frame for follow-up, and a statement of any unique or special issues requiring follow-up.

Figure 9 – Source: Nonacute provider organization audits of discharge packets
Critical Success Factors

Analysis of project data and interviews with better-performing organizations resulted in the identification of 4 critical success factors for ensuring safe and effective discharge handoff communications.

Critical Success Factor: Establish Open, Two-Way Communications

An open exchange of information is necessary for continuity of care. Stakeholders—acute and nonacute—should be encouraged to share information about their services and their discharge needs. Offer nonacute providers convenient, consistent access to information (e.g., electronic medical record, auto-faxed information, notification of admissions and discharges, pending data). Implement practices that make it easy for nonacute providers to contact knowledgeable individuals for clarification and follow-up information about their patients.

Providing patients with easy access to their personal health information will open up provider/patient communication and increase the safety and effectiveness of care. Patients and family members should be included in discussions to facilitate the recognition and communication of goals and concerns, plans for postdischarge care, and follow-up appointment scheduling.

Critical Success Factor: Define Responsibility and Accountability

Assigning responsibility for managing and following up on patient care during the transition process to specific individuals (e.g., discharging clinician, case manager, social worker, liaison) is paramount. Establish procedures that provide for 24/7 coverage, and monitor compliance with those procedures. Include discharge handoff communication goals in job descriptions, evaluations, contracts, and credentialing practices. Emphasizing the positive is also important. Celebrate successes and implement incentives and rewards/recognitions for goals that are met or exceeded.

Leaders must pave the way for improvements in the discharge handoff process by establishing them as an organization-wide performance improvement goal aligned with organizational safety and quality goals. Leaders need to provide the resources and support necessary for success and must also hold staff accountable for compliance.

Critical Success Factor: Implement Quality Assurance Practices

Regular checks of discharge information and communications are needed to ensure that high-quality discharge handoff communications are sustained. Such checks include a routine review of the discharge packet (before or after discharge) for completeness. Regularly conduct satisfaction surveys of stakeholders (nonacute providers, patients, staff, and physicians). Establish standard and consistent practices for discharge handoff communications, and share baseline and postimplementation data with all stakeholders. Evaluate current communication and quality assurance practices to make sure that they are routinely used and remain effective. Implement electronic and/or manual tools, templates, checklists, and other aids that will help staff provide comprehensive and accurate discharge communications.

Critical Success Factor: Conduct Ongoing Education and Training

Complex clinical issues, confusing regulatory standards, and regular staff turnover all contribute to the need for ongoing physician, staff, nonacute provider, and patient education. Explain the safety, regulatory, and patient satisfaction issues associated with discharge handoff communications to staff to emphasize drivers of
process improvement that extend beyond mere regulatory compliance. Share data illustrating the importance of high-quality discharge handoffs, and give examples of improvements implemented by other academic medical centers. Customize training with specific examples appropriate for each unit, department, or service. Provide convenient training tools and resources to assist staff in complying with discharge handoff policies and procedures. Teach nonacute providers how to easily access acute care information about their patients, and teach patients how to access their personal health information.

**The Time to Start Is Now**

The Discharge Handoff Communications 2008 Benchmarking Project shows that timely, comprehensive, and accurate discharge communications are not organizational priorities for many UHC members, even though discharge handoffs significantly affect quality, safety, patient and provider satisfaction, and the ability to demonstrate regulatory compliance.

This project provides detailed information and practical steps you can take to improve the transition to nonacute care. To identify opportunities for improvement, study your organization’s survey results and review the customized Performance Opportunity Summary and Scorecard sent to your organization’s benchmarking coordinator. Refer to the strategy map at the end of this field book for an overview of the project’s findings, and then use the Discharge Handoff Communications Action Plan, available on UHC’s Web site, to guide your performance improvement initiatives.

For more information about this project, contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu.

**For More Information**

To find these resources for the Discharge Handoff Communications 2008 Benchmarking Project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area. Resources available include:

- Knowledge transfer meeting presentations and Web conference recordings
- Results of acute care hospital survey, nonacute provider organization satisfaction survey, and nonacute provider organization audits of discharge packets
- Innovative strategies
- Action plan
- Sample Performance Opportunity Summary and Scorecard
- Handoff Communications listserver
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- Materials created for the Transitioning Care 2007 Benchmarking Project
Harborview Medical Center

Transitions to skilled nursing facilities. At Harborview Medical Center, a centralized discharge placement team was established to strengthen coordination with referral facility administrative teams. A designated point person coordinates with all skilled nursing facilities (SNFs). Since this centralized team was implemented, the satisfaction of placement facilities has improved, and Harborview’s ability to proactively respond to facility concerns has been enhanced. Harborview has also experienced a decrease in median length of inpatient stay for patients discharged to SNFs.

The Long Term Care Service at Harborview provides attending physician coverage to SNF patients, which facilitates coordination of care. A quarterly Long Term Care Roundtable was established with regional partners to increase collaboration with the SNF community on complex discharges. Social services staff have 24/7 responsibility as liaisons to SNFs, and discharged patients call the community care line for advice from registered nurses (RNs).

Discharge facilitation. Eleven high-level RN positions were added to fill the new role of unit-based discharge facilitator. The focus of this position is entirely on discharge planning and procedures. On each unit, the discharge facilitator huddles twice a day with physicians, nurses, and staff from social services, pharmacy, nutrition, finance, etc., to identify and address barriers to timely discharge. There is a hard stop on transfers when the discharge process is incomplete.

In conjunction with the UHC Managing Patient Flow Implementation Collaborative in 2004, Harborview developed a comprehensive discharge process algorithm detailing the steps to be completed prior to discharge (Appendix B).

Ongoing initiatives. Harborview continues to refine discharge practices and is currently focused on improving the management of patients discharged to home with outpatient care:

- One consistent process is now used for scheduling, financial clearance, and referrals; the electronic platform is accessible to all Harborview stakeholders.
- At discharge, Harborview patients receive a single phone number (744-DCRN) to call if they have questions about postdischarge care.
- An After Care Clinic has been created to provide follow-up care for transients and patients without a primary care physician. This clinic, which does not require additional full-time equivalent employees, has significantly reduced the no-show rate at the organization’s primary care clinics.
- Templates and check lists have been designed to help clinicians provide the necessary discharge information. A long-term goal is to have discharge summaries available on the day of discharge for all patients.

For more information, contact Debra Gussin, director, Ambulatory Care, Harborview Medical Center, at (206) 744-2917 or dgussin@u.washington.edu.

Massachusetts General Hospital

Clinical Transitions project. The Clinical Transitions project at Massachusetts General Hospital (MGH) and Partners HealthCare System, Inc, began in 2003 and has been expanded over time. The project originally focused on the communication of 7 essential data elements for transitions from acute care to nonacute care: physician contact, procedures, hospital course, medications (preadmission and discharge medication list), allergies, follow-up plans, and warfarin use (indication, monitoring parameters, sufficient information for the next 72 hours). The goal is to include all 7 items in all discharge packets; performance is measured with a formula that determines the “defect-free rate.” The initial audit revealed that none of the discharge records reviewed were defect-free.
MGH has made several improvements in the area of information technology, including expanding the electronic discharge module to include required fields for allergies, discharge medications, follow-up care, and procedures. Use of the preadmission medication list module is compulsory. An anticoagulation therapy module has also been developed and implemented.

Training is an important component of discharge handoff improvements at MGH. A discharge summary tutorial for medical house staff has been created, and a tutorial for surgical house staff is being developed. Training modules will be available to attending staff as well as house staff.

Feedback on discharge handoff performance is provided on the individual and department levels. An intervention using e-mail to provide feedback to the discharging clinician (with a summary report for the program director and service chief) is currently being tested.

Incentives have been built into the discharge improvement process. The hospitalist and clinician-teacher services have bonuses tied to the inclusion of critical transition data elements in discharge handoff communications. Consideration is being given to expanding the use of incentives to other services. MGH is also exploring the inclusion of transition elements in the next pay-for-performance contract for all clinicians.

The Partners hospital with the best rate of defect-free discharge records is a community hospital that uses paper charts. The information technology infrastructure at this facility has developed more slowly, but case managers “sweep” all outgoing discharge packets for essential elements, identify omissions, and find the required data before the patients are discharged.

The defect-free rate metric requires global improvement for all required data elements before the score improves significantly. MGH has seen steady improvement in its defect-free rate over time (Figure 10). Future plans include developing required data sets for congestive heart failure and end-of-life care.

For more information, contact Terrence O’Malley, MD, medical director, Non-Acute Care Services, Partners HealthCare System, Inc, at (617) 724-4838 or tomalley@partners.org.

University of Michigan Hospitals and Health Centers

Discharge navigation system and admission workflow. At University of Michigan Hospitals and Health Centers, a site-developed discharge navigation system gathers essential information to help clinicians build the discharge summary. The system also generates patient education materials for use by nurses and in the patient

Discharge Handoff Communications at Massachusetts General Hospital

- The ongoing Clinical Transitions project started 5 years ago has resulted in significant discharge documentation improvement. For example, a recent medication reconciliation audit shows 98% compliance.
- Site-developed discharge documentation software collects data to help clinicians generate the comprehensive discharge packet.
  - The data include preadmission and discharge medications, diagnoses, procedures, therapies, physician’s discharge orders, and nursing notes.
- Hard stops force comprehensive discharge documentation.
  - Completion of the preadmission medication list is prompted within 24 hours of admission.
  - Physicians cannot discharge a patient without performing medication reconciliation.
  - Clinicians have been educated about the importance of discharge documentation and medication reconciliation for safety and quality.
- Patients cannot be discharged from the facility without receiving a copy of their discharge packet.
discharge report. Each service adapts the system for the unique needs of its patients. The tool standardizes the discharge process and facilitates timely completion of the discharge summary; 100% of inpatients receive their summaries at the time of discharge.

The components of the Admission Workflow Report are built step-by-step starting at the time of admission; essential data are auto-populated from the electronic medical record. Templates are customized by service, procedure, or condition, and the diagnosis list and medication reconciliation are integrated with the problem summary list. Reports are completed and reviewed with patients on the day of discharge.

**MNET program.** MNET is the health system's referring physician communication network. MNET links participating physicians with the health system to deliver patient and hospital services information electronically. Currently, 15,000 referring/receiving physicians are enrolled in the program, which automatically faxes clinical information about their patients. This program strengthens the relationship between referring physicians and Michigan and improves patient care, which in turn enhance Michigan's strategic competitiveness.

**Performance measurement.** Every 2 years, Michigan conducts a statewide referring physician survey. A 12% response rate was achieved for the most recent survey of 20,000 physicians, and 81% indicated the likelihood of continuing to refer patients to Michigan. In addition, medical record audits, safety rounds, and Press Ganey patient satisfaction data are used to monitor the effectiveness of discharge processes and handoff communications.

**Postdischarge appointment pilot.** A discharge follow-up appointment pilot project is currently under way. The project goals include scheduling follow-up ambulatory appointments at least 24 hours before a patient’s departure. The appointment is made with patient/family involvement, and the Michigan physician is notified of the appointment status. Nurses include the follow-up appointment information in the discharge instructions.

This process has many benefits. The timing of the appointment is based on patient and caregiver preferences. Verification of the

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**At Michigan, a referring physician survey, medical record audits, safety rounds, and Press Ganey patient satisfaction data are used to monitor the effectiveness of discharge processes and handoff communications.**
patient’s primary care physician and insurance can occur prior to patient departure. The clinic can be notified of any special circumstances (e.g., wheelchair or translator needed). The patient can receive directions to and parking information for the follow-up clinic, and preparation instructions for all scheduled tests can be included in the discharge instructions. Early data from the pilot indicate improvements, including reducing the no-show rate for clinics and decreasing the 30-day readmission rate.

For more information contact Carol Barnett, clinical nurse consultant, University of Michigan Hospitals and Health Centers, at (734) 936-3509 or cbarnett@med.umich.edu, or Josie Aguirre, director, Physician and Consumer Communications, University of Michigan Hospitals and Health Centers, at (734) 763-6703 or jaguirre@umich.edu.

University of North Carolina Hospitals
Discharge handoff communications for frail elders. When the community raised concerns about appropriate discharge planning for frail elders, the University of North Carolina Hospitals’ (UNC’s) care management department used an audit process to validate the perception. Thirty-three of the 547 charts reviewed (6%) had a flaw in the discharge plan. Of the 33 charts with a flaw, 24 were for patients who were admitted for less than 48 hours. Many patients spent up to 12 hours in the emergency department. This information suggested that care management staff were missing frail elders with a short length of stay.

In response, UNC’s care management staff visited nonacute provider settings and invited nonacute providers to the hospital to build relationships and establish two-way communications. Transitional care initiatives for vulnerable elders focused on continuing care retirement communities (CCRCs). Access to the electronic medical record for affiliated CCRCs was implemented. Efforts were directed at increasing direct admissions and reducing access via the emergency department, so a hospital admission form was created by the CCRCs and is faxed directly to the care management department at the hospital.

The geriatric nurse practitioner and the care managers now serve as liaisons for nonacute providers, and the care management software and the physician documentation software have been interfaced to provide easy access to essential information.

Hospital staff were educated about the levels of care offered by CCRCs. Staff and physicians receive education (customized for each service) on the safety, regulatory, and patient satisfaction issues relevant to the discharge process.

As a result of these efforts, complaints about the discharge of frail elderly patients have significantly decreased; no complaints were received during the 5-month postimplementation period. The CCRCs are thrilled to have a point person for communication, and access to the electronic medical record helps them follow the care plan. The UNC staff feel that communication from CCRCs at admission helps them plan more effectively.

Patient transportation. Another discharge handoff challenge was the patient transportation process, which was considered “inefficient and ripe for errors.” Procuring and documenting discharge transportation was a multistep, multi–computer program, multi-handoff process. Individuals making choices about transportation did not have an effective tool to help them identify important variables.

To improve this important aspect of the discharge process, the Transportation Review and Improvement Process was initiated. A work group created a transportation form to be used as part of the electronic discharge summary. (The summary software prepopulates fields with medications, diagnoses, major procedures, treatments, etc., to make it easy for physicians to generate.) The electronic form accommodates all forms of transportation, and arrangements for previous admissions are available for viewing. Patient transportation vendors have reported improved satisfaction with the new system.
For More Information
To find these resources for the Discharge Handoff Communications 2008 Benchmarking Project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area. Resources available include:

- Knowledge transfer meeting presentations and Web conference recordings
- Results of acute care hospital survey, nonacute provider organization satisfaction survey, and nonacute provider organization audits of discharge packets
- Innovative strategies
- Action plan
- Sample Performance Opportunity Summary and Scorecard
- Handoff Communications listserver
- Information about the Discharge Handoff Communications 2008 Implementation Collaborative
- Materials created for the Transitioning Care 2007 Benchmarking Project

References


3. Audit questions were adapted with permission from the Partners HealthCare System, Inc, Clinical Transitions project (2007) led by Terrence A. O’Malley, MD; Jeffry Schnipper, MD; Carmen Varga-Sen; and Myrna Chan-MacRae.


Next steps. UNC continues to build on the lessons learned from their frail elderly and transportation handoff projects:

- Continuously reassess work processes.
- Welcome feedback from postacute providers.
- Identify communication gaps.
- Convene cross-functional work groups.
- Identify “true requirements” versus “institutional history.”
- Obtain data to prioritize opportunities.
- Select 2 or 3 initiatives for focused improvement or efforts.
- Demonstrate the value of the program both quantitatively and qualitatively.
- Start focused, demonstrate success, and then expand the program.
- Celebrate!

Current improvement efforts are focused on discharge handoff communications for patients discharged with home health care and ongoing staff education initiatives.

For more information, contact Janet Hadar, director, Care Management, University of North Carolina Hospitals, at (919) 843-0020 or jhadar@unch.unc.edu.
This document is designed to help you identify your academic medical center (AMC) acute care hospital’s strengths and opportunities related to discharge communications with nonacute care providers. An action plan should be created to address items suggested for follow-up. The resources available to assist in developing action plans include the project findings, knowledge transfer presentations, and the innovative strategy reports submitted by project participants. These documents and other resources can be accessed via UHC’s Web site at www.uhc.edu, select “Improvement & Effectiveness,” “Benchmarking,” and “Discharge Handoffs.” Contact Kathy Vernoch at 631/954-1030 or vernoch@uhc.edu with questions about the discharge handoff communications study.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Hospital Value</th>
<th>Benchmark/Maximum</th>
<th>Best Quartile</th>
<th>Best Decile</th>
<th>Follow-up Suggested</th>
<th>Potential Improvement Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean of the overall average satisfaction scores of nonacute provider organizations</td>
<td>0.25</td>
<td>1.00</td>
<td>0.20</td>
<td>0.34</td>
<td>Yes</td>
<td>20% difference from the benchmark</td>
</tr>
<tr>
<td>Hospital discharge handoff communications self-assessment score</td>
<td>0.60</td>
<td>1.00</td>
<td>0.46</td>
<td>0.69</td>
<td>Yes</td>
<td>37% difference from the benchmark</td>
</tr>
<tr>
<td>Difference/gap between hospital nonacute satisfaction and self-assessment scores</td>
<td>-0.35</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall percentage of key handoff information present in the discharge communications audited</td>
<td>80%</td>
<td>100%</td>
<td>91%</td>
<td>94%</td>
<td>Yes</td>
<td>20% difference from the benchmark</td>
</tr>
</tbody>
</table>

**Subset of Effective Discharge Handoff Communication Practices**

<table>
<thead>
<tr>
<th>Bundled Score Above</th>
<th>Hospital Value</th>
<th>Benchmark</th>
<th>Respondents Achieving Benchmark</th>
<th>Follow-up Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Discharge handoff improvement goals are formally aligned with organizational quality/safety goals</td>
<td>Yes</td>
<td>Yes</td>
<td>71%</td>
<td>Yes</td>
</tr>
<tr>
<td>• The hospital requires responsible discharging clinicians to communicate directly with the receiving nonacute provider before discharge/transfer</td>
<td>Yes</td>
<td>Yes</td>
<td>67%</td>
<td>Yes</td>
</tr>
<tr>
<td>• Hospital staff are defined/designated to follow-up and manage the patient’s care prior to the first appointment for patients discharged to home/ambulatory care</td>
<td>Yes</td>
<td>Yes</td>
<td>10%</td>
<td>Yes</td>
</tr>
<tr>
<td>• Hospital staff are defined/designated to follow-up regarding significant diagnostic test results pending at the time of discharge</td>
<td>Yes</td>
<td>Yes</td>
<td>29%</td>
<td>Yes</td>
</tr>
<tr>
<td>• The goal for completion of the final discharge summary is “at time of discharge”</td>
<td>Goal not established</td>
<td>At time of discharge</td>
<td>29%</td>
<td>Yes</td>
</tr>
<tr>
<td>• Discharge planning is initiated during preadmission or within 24 hours of admission</td>
<td>Sometimes/only for selected units</td>
<td>Always/almost always</td>
<td>67%</td>
<td>Yes</td>
</tr>
<tr>
<td>• The medication reconciliation process is performed at time of discharge</td>
<td>Always/almost always</td>
<td>Always/almost always</td>
<td>81%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Legend**

- Follow-up Suggested
- Worse Than Best Quartile
- No Data For Your Institution

1. Project data were derived from several sources: a survey and self-assessment of discharge communication practices was completed by the AMC hospital. Nonacute provider organizations identified by the AMC hospital performed an audit of discharge information received and rated their satisfaction with the AMC hospital’s discharge communications. The medical literature was researched, project participants submitted innovative strategy reports, and selected acute and nonacute care organizations were interviewed.

2. The mean of the overall average satisfaction scores for all nonacute provider organizations reporting satisfaction with the hospital’s discharge handoff communications, (e.g., total overall average scores divided by the number of nonacute providers.) Hospitals with only 1 nonacute provider satisfaction score reported were trimmed from the calculation of aggregate statistics. The overall average score for each nonacute provider = the sum of responses to satisfaction survey questions 11 through 21 where Agree = 1.00, Neutral = 0.00, and Disagree = -1.00 divided by the total number of responses. Maximum obtainable score = 1.0. Follow-up is suggested if organizational value is less than the benchmark.

3. Hospital self-assessment score, e.g., agreement with statements about effective organizational discharge handoff communication practices; weighted total score = summary of scores for responses to hospital survey questions 21 through 33 divided by total number of responses (Agree = 1.00, Neutral = 0.00, Disagree = -1.00 maximum average score = 1.00.) Follow-up is suggested if organizational value is less than the benchmark.

4. Total “Yes” and “Not Applicable” audit responses divided by the total number of audit questions multiplied by 100 for all nonacute providers reporting for each hospital. The improvement opportunity is the difference from the benchmark. Hospitals with fewer than 10 total records reported were trimmed from the calculation of summary statistics.

5. Effective discharge handoff communication practices bundled score = the total number of responses for each of the 7 key handoff practices listed at the benchmark, divided by 7, and multiplied by 100. The improvement opportunity is the difference from the benchmark. Hospital survey questions 8, 9, 10, 14, 16, 17, and 40 included.

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### UHC 2008 Discharge Handoff Communications Benchmarking Project Performance Opportunity Summary and Scorecard

**Generic Hospital**

This document is designed to help you identify your academic medical center (AMC) acute care hospital’s strengths and opportunities related to discharge communications with nonacute care providers. An action plan should be created to address items suggested for follow-up. The resources available to assist in developing action plans include the project findings, knowledge transfer presentations, and innovative strategy reports submitted by project participants. These documents and other resources can be accessed via UHC’s Web site at [www.uhc.edu](http://www.uhc.edu), select “Improvement & Effectiveness,” “Benchmarking,” and “Discharge Handoffs.” Contact Kathy Vermoch at 630/954-1030 or vermoch@uhc.edu with questions about the discharge handoff communications study.

### Additional self-assessment questions for implementing safe and effective discharge handoff communication practices; follow-up suggested for any “no” responses.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior leaders have established safe and effective internal and external handoff communications as an organization-wide goal.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Discharge/transfer procedures and communications are consistent across acute care inpatient services.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospital staff have a thorough understanding of the levels of care and services provided by nonacute provider organizations.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Inpatient caregivers have an accurate understanding of the discharge information needed by nonacute provider organizations.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Effective two-way communication channels are in place between acute and nonacute providers.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Primary care and referring providers are regularly and promptly notified about their patients’ admissions, discharges, and other significant events.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nonacute providers can easily identify and contact appropriate individuals to clarify information about inpatient care and treatment.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The satisfaction of nonacute providers is periodically measured to promote effective discharge handoff communications.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Audits of discharge information are routinely conducted to evaluate the effectiveness of discharge handoff communications.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Procedures/incentives are in place to motivate compliance with discharge handoff procedures and hold staff accountable.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tools, templates, and procedures are in place to help hospital staff generate timely and comprehensive discharge information.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Skilled nursing facilities almost always receive discharge orders in advance of the patient’s arrival to help them prepare to meet the patient’s needs.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A comprehensive list of preadmission and discharge medications is routinely included with the discharge information.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nonacute providers that frequently receive patients discharged from acute care have easy/convenient access to their patients’ electronic inpatient health records.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Procedures are in place to evaluate patient compliance with post-discharge instructions and ambulatory appointments.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Competent patients/families participate in the scheduling of post-discharge ambulatory appointments.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Legend**

- ✔ Follow-up Suggested
- ☐ Worse Than Best Quartile
- ☐ No Data for Your Institution

1. Project data were derived from several sources: a survey and self-assessment of discharge communication practices was completed by the AMC hospital. Nonacute provider organizations identified by the AMC hospital performed an audit of discharge information received and rated their satisfaction with the AMC hospital’s discharge communications. The medical literature was researched, project participants submitted innovative strategy reports, and selected acute and nonacute care organizations were interviewed.

2. The mean of the overall average satisfaction scores for all nonacute provider organizations reporting satisfaction with the hospital’s discharge handoff communications (e.g., total overall average scores divided by the number of nonacute providers). Hospitals with only 1 nonacute provider satisfaction score reported were trimmed from the calculation of aggregate statistics. The overall average score for each nonacute provider = the sum of responses to satisfaction survey questions 11 through 21 where Agree = 1.00, Neutral = 0.00, and Disagree = -1.00 divided by the total number of responses. Maximum obtainable score = 1.0. Follow-up is suggested if organizational value is less than the benchmark.

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Discharge Process Algorithm

**Day of Admission**
- Identify PCP on Admit
- Identify estimated LOS & Discharge date
- Identify likely disposition on admission
- Identify insurance benefit coverage
- Where are meds filled? What is pharmacy preference?
- SW to screen discharge needs
- Therapy consult

**PATIENT DISPOSITIONS**
- HOME
- SNF
- REHAB

**3 Days Prior to Discharge**
- PICC/PEG
- Talk to Pt & Family

**2 Days Prior to Discharge**
- PICC/PEG/Restraint off
- Talk to Pt & Family

- PICC/PEG
- Talk to Pt & Family

- Doesn’t need restraints off

- Diagnostics completed
- Labs ordered

- Consults completed

- Interim Summary if requested by UDF or SW

- Rehab MD consult
- Discharge Summary

- Discharge medication orders
- Complete Speciality Appt F/U Form

- Confirm destination
- Confirm transportation
- Confirm funding for placement
- Consent to transfer

**1 Day Prior to Discharge**
- Discharge pending requirements complete

- Teaching
- Discharge Appt
- Cleared by therapy

- Confirm transportation

**Day of Discharge**
- Physician Discharge Order

**Discharge**
- Call report

**Legend**
- Blue = MD
- Yellow = Discharge Team
Discharge Handoff Communications Strategy Map

What Are Handoff Communications?

- A handoff is "the transfer of information (along with authority and responsibility) during transitions in care across the continuum for the purpose of ensuring the continuity and safety of the patient's care." 1
- Effective [handoff] communication is "timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved [patient] safety." 2

Challenges

Errors in discharge handoff communications are associated with adverse outcomes, including incorrect or delayed diagnoses and treatments and life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer life-threatening adverse events, reduced customer satisfaction, regulatory deficiencies, and increased health care expenditures due to avoidable readmissions, emergency department visits, and longer

What Was Studied

- Twenty-one academic medical centers (AMCs) completed a hospital survey and self-assessment.
- Sixty-one nonacute provider organizations, reporting for 19 AMCs, responded to a satisfaction survey.
- Fifty-one nonacute provider organizations, reporting for 17 AMCs, audited the records of 413 patients transferred into acute care.
- All project participants, including better-performing organizations, have improvement opportunities related to their discharge handoff communication process.

Project Focus/Objectives

- Evaluate inpatient discharge practices to assess current performance and identify improvement opportunities.
- Probe the discharge handoff needs of nonacute care providers and rate their satisfaction with current practices.
- Collect and communicate successful strategies used to demonstrate regulatory compliance and ensure safe, effective, and comprehensive discharge handoff communications.

Key Performance Measures

- Average satisfaction scores from nonacute provider organizations.
- Hospital discharge handoff communication self-assessment score.
- Percentage of key handoff information present in audited discharge communications.
- Effective discharge handoff communication practices bundled score.

Most Important Take-aways

- Open, two-way communications must be established between acute and nonacute care settings so that providers can effectively understand and address information needs.
- Responsibility must be defined for managing and following up on patients during the discharge transition process.
- Hospitals must make sure that discharge communications are timely, accurate, and complete before asking for high-quality admission information about patients transferred into acute care.
- All project participants, including better-performing organizations, have improvement opportunities related to their discharge handoff communication process.

Implement Quality Assurance Practices

- An open exchange of information is necessary for safe and effective continuity of care.
- Invite acute and nonacute stakeholders to share information about their services and discharge handoff needs.
- Offer nonacute providers convenient, consistent access to information (e.g., electronic medical records, auto-faxed information, and notification of admissions, discharges, and pending data).
- Implement practices that make it easy for nonacute providers to contact knowledgeable individuals for clarification and follow-up information.
- Enable patients to easily access their personal health information.
- Work with patients and family members to recognize and communicate goals and concerns, plan for postdischarge care, schedule follow-up appointments, etc.

CRITICAL SUCCESS FACTORS

Implement Open, Two-Way Communications

It is necessary to implement regular checks to ensure the ongoing high quality of discharge handoff communications.

- Evaluate current communication and quality assurance practices to make sure they are used appropriately and remain effective.
- Routinely audit the information included in discharge packets (before or after discharge).
- Regularly survey nonacute providers, patients, staff, and physicians about their satisfaction with discharge procedures.
- Establish standard and consistent practices for discharge handoff communications across the acute care facility. Collect and widely share baseline and postimplementation data.
- Implement electronic and/or manual tools, templates, checklists, and other aids to help staff provide comprehensive and accurate discharge communications.

Define Responsibility and Accountability

Leaders must demonstrate that effective handoff communications are an organizational priority.

- Establish effective handoff processes as an enterprise-wide performance improvement goal that is aligned with safety and quality goals and supported by the resources necessary for success.
- Assign responsibility for managing and following up on a patient’s care during the discharge transition process to specific individuals (e.g., discharging clinician, case manager, social worker, liaison).
- Establish procedures for 24/7 coverage and monitor compliance.
- Include discharge process goals in job descriptions, evaluations, contracts, and credentialing practices, and hold staff accountable for expected performance. Provide incentives, rewards, recognitions, and celebrations for success.

Conduct Ongoing Education and Training

Complex clinical issues, conflicting regulatory standards, and regular staff turnover all contribute to the need for ongoing physician, staff, nonacute provider, and patient education.

- Educate physicians and staff about the safety, regulatory, and patient satisfaction issues that are associated with ineffective discharge handoff communications.
- Share data illustrating the importance of high-quality discharge handoffs, and give examples of improvements implemented by other AMCs.
- Customize training with specific examples appropriate for each unit, department, or service.
- Develop convenient training resources and tools to assist staff in complying with discharge handoff policies and procedures.
- Instruct nonacute providers in procedures for easily accessing acute care information about their patients for follow-up and clarification.
- Teach patients how to access their personal health information.

Goal

The provision of consistent, comprehensive, accurate, and timely discharge handoff communications that ensure the safety and quality of care provided to patients discharged from acute care.

Action Plan

To implement the tactics listed in this Strategy Map, use the Discharge Handoff Communications Action Plan. This workbook template can be used to identify actions needed, instructions, responsible parties, due dates, completion dates, and results/comments. To find the action plan and other project documents, including the field book, knowledge transfer meeting presentations, Web conference recordings, survey and audit results, innovative strategies, and the sample Performance Opportunity Summary and Scorecard, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area.

UHC’s Discharge Handoff Communications 2008 Implementation Collaborative (including a listserver) is also available for networking and sharing information with colleagues. Contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu for more information about UHC’s Discharge Handoff Communications initiatives.

26

27
Publication Summary

To find these resources for the Discharge Handoff Communications 2008 Benchmarking Project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area.

Field Book—This project guide is a comprehensive overview of the most significant project findings and recommendations. It will help you make the best use of performance assessments and other tools to improve discharge handoff communications.

Knowledge Transfer Meeting Presentations and Web Conference Recordings—Resources include presentations on the project findings and how to use them, presentations by the better performers, and recordings of 2 Web conferences.

Results of Surveys and Audits of Discharge Packets—These comprehensive reports contain all data collected for the project. The data give a clear idea of how all participants compare across the full range of performance measures.

Innovative Strategies—This compendium has specific tactics that project participants have used to improve performance.

Action Plan—This detailed list of successful strategies and tactics is in an action plan format to guide your improvement initiatives.

Sample Performance Opportunity Summary and Scorecard—This example shows how the customized report compares each organization's performance with the project benchmarks to help identify and prioritize improvement opportunities.

Project Manager
For more information about the Discharge Handoff Communications 2008 Benchmarking Project, contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu.