THE EFFECTS OF PATIENT HANDOFF PROCESSES ON COMMUNICATION AND CARE TRANSITIONS: A QUALITY IMPROVEMENT PROJECT

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INTRODUCTION

- Asthma accounts for nearly 1/3 of pediatric asthma costs and upwards of 40% of those are repeat admissions (Kenyon et al., 2014).
- 2/3 of sentinel events are caused by communication errors with 1/2 involving handoff failures (Starmer et al., 2014).
- Handoff failures & poor communication result in inadequate treatment, delays in care, & adverse events after hospitalization. (Arona & Johnson, 2006; Desai, Popalisky, Simon, & Mangione-Smith, 2015).

Literature Review

- By using the I-PASS handoff mnemonic, the medical-error rate decreased by 23% between the pre- and post-intervention periods and the rate of preventable adverse events decreased by 30% (Starmer et al., 2014).
- 3 Children’s Asthma Care (CAC) core process measures linked the family and the PCP to give the family support and follow-up treatment (Bergert et al., 2014, Patel et al., 2015).
- For those children hospitalized with asthma, adherence to asthma care measures & attendance at follow-up appointments resulted in decreased readmission rates (Bergert et al., 2014).
- Follow-up phone allow families/patients to ask questions, troubleshoot unforeseen problems and guide medical care (Harrison, Hara, Pope, Young, and Rula, 2011).

PICOT & OBJECTIVES

PICOT

For empaneled PCMH patients discharged with a first-listed diagnosis of asthma (P), how does the use of a standardized handoff process by the care coordinator (I) compared to a non-standardized handoff process (C) affect the nurses ability to complete the post discharge follow up call to assess for medication adherence, self-care, scheduled follow-up appointments, and/patient/family questions, and, subsequently, readmissions and ED follow up visits (O) over a three month period (T)?

OBJECTIVES

1. 100% of Primary Care Clinic (PCC) care coordinators and Inpatient care coordinators will be educated on the use of the I-PASS Tool and the Project RED Tool by October 15, 2016.
2. Between November 1, 2016, and January 15, 2017, 100% of empaneled PCMH patients discharged with a first-listed diagnosis of asthma, will have their important healthcare needs communicated to the PCC care coordinators using the I-PASS Tool.
3. Increase the number of PCMH empaneled patients, with asthma as a first-listed diagnosis, who are successfully called using the Project RED Follow-up Phone Call Tool after discharge.
4. Anecdotal, the PCC care coordinators report of the nine patients who did not keep their follow-up appointment, they were able to reach 8 via the phone; seven (77.7%) patients shared they were unaware there was a follow-up appointment scheduled for their child.

RESULTS

- 19 empaneled PCMH patients admitted with first-listed diagnosis of asthma during the timeframe.
- 15.8% of patients admitted with asthma exacerbation diagnosis (n = 3), 26.3% admitted with status asthmaticus diagnosis (n = 5), and 57.9% were admitted with asthma diagnosis (n = 11).
- There was no statistically significant difference in the reason for admission and asthma illness severity, χ²(6) = 6.152, p = 0.41.
- The denominating diagnosis of status asthmaticus was a highly motivating factor in keeping post-hospital follow up appointments, χ²(2) = 6.116, p = 0.05, ϕ=0.36.
- Those admitted with general asthma were more likely to miss their follow up appointment, p = 0.05, ϕ=0.46.
- Some patients had other needs such as homelessness, home environmental concerns (mice and mold), and previous history of not keeping appointments (51 previous no shows for clinic appointments).
- Compared to the same time frame in the previous year, there was a 73.7% increase in the number of patients who were successfully called using the Project RED Follow-up Phone Call Tool after discharge.

MEASURES

- All elements on both tools: The PCC Care Coordinator assessed for the following and intervened as needed:
  - Knowledge of the follow-up appointment
  - Return to attendance
  - Knowledge of medication
  - Urging medical and/or social concerns
  - What to do in a non-emergent problem occurrence

OUTCOMES

- OBJECTIVE 1 MET: 100% care coordinators educated on the use of the tools
- OBJECTIVE 2 MET: 100% empaneled PCMH patients with first-listed diagnosis of asthma had important medical needs communicated to PCC Care Coordinators using I-PASS Tool
- OBJECTIVE 3 MET: 73.7% increase in patients successfully called using Project RED Tool after discharge
- OBJECTIVE 4 MET: 100% of patients admitted during the project timeframe were scheduled for post-hospital follow-up appointment

CONCLUSIONS

- All 4 objectives were met
- Project Limitations:
  - Seasonal variation in illness
  - Small Sample Size
  - Retracing this project during spring or fall to capture weather-related asthma exacerbations or expansion to include patients who see a primary care provider in the West location, the Beacon (Complex) Clinic, and/or the Teen Clinic
  - There is interest in expanding this process to include all PCMH patients admitted to the hospital or Emergency Department

REFERENCES


ACKNOWLEDGEMENTS

A special thank you to the people who assisted in the project:
Dr. Mary Rich, Committee Chair
Dr. Laurena Dwyer, Committee Member
Dr. Stacy Doyle, Committee Member
Dr. Tom Peterson, Statistics Assistance
Inpatient and PCC Care Coordination at Children’s Mercy Kansas City

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