Transition of Care from Acute Hospitalization to the Patient Centered Medical Home: An electronic handoff

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The Problem

- Transitions of care between the hospital and the patient centered medical home (called Patient Aligned Care Teams-PACT in the VA) is a high risk period for patients
- Discharge summaries are the main tool to communicate the clinical course and post-discharge follow-up needs, but are fraught with problems including timeliness, delivery, and missing information

Project Goal(s)

- Create and implement an easy to use EMR tool that communicates the critical information needed by key stakeholders for the hospital to outpatient transition of care
- Tool must be self-explanatory, requiring no training
- Tool must be in continued use and self-sustaining by goal deadline June 1, 2011

Project Plan

The key components required in a handoff were determined through interviews of key stakeholders in the transition of care from inpatient to outpatient care. We then created an electronic tool in the VA’s EMR that communicates critical information from the hospital to the PACT teams. The tool (called the PACT handoff) contains provider contact info, discharge date, follow-up appointments, pending labs/tests/imaging, hometown services, and other information deemed important by housestaff physicians. It is completed by medicine housestaff physicians and is automatically delivered to the PACT RN who then assesses the information and passes on necessary clinical information to the provider.

Results / Progress to Date

Progress Notes
Procedure/imaging/Lab Reports
Discharge Summary - Varying Completion Time by Inpatient Teams
Follow-Up Appointment with PCP

Step 1. Patient Discharged w/ Discharge Instructions Note
Step 2. Discharge View Alert automatically sent to PCP in CPRS
Step 3. PCP gathers Discharge Information - From multiple sources. Requires multiple checks in the EMR at different times.
Current Information Flow from Inpatient to Outpatient
Timeline
Handoff Tool Information Flow

Lessons Learned

1. Implementing simple tools that improve the ability to deliver good care while not imposing excessive burdens on stakeholders can have rapid uptake and may be spread effectively.
2. Although EMRs and discharge summaries are comprehensive in nature, meaningful clinical communication depends on efficiently delivering the “need to know” pieces of information.

Next Steps

- Bundling of handoff tool with a medication reconciliation tool
- Wider dissemination with clinics and hospitals outside of the SVAMC network
- Chart review to determine if handoff leads to improved time to primary care follow-up visit
- Survey of primary care providers, outpatient RN case managers, and inpatient residents on satisfaction of tool

Qualitative Results

Outpatient: RN case managers (10) focus group
- Response generally positive.
- Appreciated the alerting function the tool served when the patient was discharged.
- Note prompted the discovery of missing follow-up appointments and long wait times >1 month. Clinic staff able to intervene to correct these issues.

Inpatient: Medicine housestaff (7) focus group
- Response overwhelmingly positive.
- Six of the housestaff had readily adopted the tool without any formal training.
- Reported taking <2 minutes to complete the handoff.
- Felt more reassured that patients would have appropriate follow-up and that important clinical information was being communicated.
- Unable to elicit any negative aspects of the tool

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