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## TALKING POINTS: TRANSITIONS OF CARE

### Failed Transitions lead to substantial costs, morbidity, mortality, and reputational risk

- Nearly one in five patients experiences an adverse event (AE) during the transition from the hospital to home. Research shows that one third of the AEs may be preventable and another third could be ameliorated. Ineffective communication represents the major factor leading to such events. The majority of AEs in one study (66%) were related to medications.<sup>1</sup>
- Almost half of patients discharged from hospitals have lab results still pending and outpatient physicians may be unaware of almost two thirds of the results, despite the fact that 12.6% require urgent action.<sup>2</sup>
- One study found that outpatient workups were recommended on approximately one third of patients being discharged from the hospital, but these workups were not completed more than a third (35.9%) of the time. The most common workups not completed were CT scans to follow up on abnormalities seen on previous x-rays and endoscopic procedures to follow up on gastrointestinal bleeding.<sup>3</sup>
- **OPTIONAL POINT**  
Internal medical-legal data reveals that handoff issues not only represent significant quality and service problems for \_\_\_\_\_ (hospital name) patients, but they also represent financial liability to our organization. In 2007 (or whatever time period), medical-legal costs involving handoff issues exceeded \$\_\_\_\_\_ or an average of \$\_\_\_\_\_ per claim. These cases specifically involved \_\_\_\_\_ (e.g., handoff issues between departments or providers, patient/family non-compliance, or lack of patient education). This may be confidential and sensitive information that some institutions would be reluctant to share so you should omit this if there is not a culture of “open disclosure”, or consider enlisting senior leaders, a department chief, or quality personnel to obtain relevant information and speak to this aspect.

#### *Insert your local data here:*

- Service/Patient Satisfaction/H-CAHPS scores
- PCP feedback/satisfaction rates
- Readmission Rates
- Attachment with story of a patient’s adverse event or problematic outcome after discharge from your Hospital

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## Hospital discharge is a critical transition point in need of redesign

- Nearly half (49%) of hospitalized patients experience at least one medical error in medication continuity, diagnostic work-up, or test follow-up.<sup>5</sup>
- A study of patients surveyed at discharge to assess their knowledge revealed the following: only 41.9% were able to state their diagnosis or diagnoses; 27.9% were able to list all their medications; 37.2% were able to state the purpose of their medications; 14% were able to state common side effects of their medications.<sup>6</sup>
- The availability of a discharge summary at the first post discharge visit was low (12-34%) and remained poor (51-77%) at 4 weeks, affecting the quality of care in approximately 25% of follow-up visits and contributing to primary care physician dissatisfaction.<sup>7</sup>
- Literature on hospital discharge suggests that interventions aimed at reliable handoff communications between a primary care provider (PCP) and Hospitalist, close follow-up and engagement of patients and families may significantly reduce adverse events.<sup>8,9,10</sup>
- In addition to the growing literature on discharge process failures and financial liabilities, regulatory agencies such as The Joint Commission (TJC), Centers for Medicare & Medicaid Services (CMS), and National Quality Forum (NQF) are now focusing on handoffs and transitions of care.

## References

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