An Ensocare White Paper

ENSOcare
— Care Coordination Solutions —

Leveraging Your Existing EMR

to Increase Patient Handoff Reliability

Patient handoffs—transitioning patient information, authority and responsibility from one provider to another—occur continuously throughout a patient's care episode. In a typical teaching hospital, for example, there are approximately 4,000 patient handoffs every day. Although common, these transitions often leave room for potential errors and mistakes and put patients at risk.

The consequences of patient handoffs can be significant. In fact, incomplete and insufficient transitions contribute to 80 percent of preventable adverse events.[1]

While all handoffs have the potential for communication breakdown and inadequate data transfer, one of the most precarious transitions is when a patient leaves an acute-care hospital for another setting, which may be a different hospital, a post-acute care facility or their own home.

Why Patient Discharge Handoffs are So Risky

Discharge handoffs in most hospitals are inherently flawed because the processes surrounding them rely in large part on interpersonal communication between the discharge planner and the patient/family. If there is a disconnect between these two entities, a smooth and successful transition is hard to achieve.

Another obstacle to smooth and successful discharges is the lack of standardization in how the hospital compiles and then transfers information with the facility next in line in the transition. The receiving facility may or may not get the information it needs to continue a patient's care, or to coordinate with community resources. Or the information may not be transmitted in a timely fashion.

Even if a hospital has defined discharge processes, the steps in the process are often delayed until shortly before a patient leaves the hospital. These delays can result in the critical information exchange step being rushed and in valuable clinical details being omitted.

Potential Consequences

Flawed discharge handoffs impact everyone involved, from the patient to discharge planners to the hospital itself. For the patient and the discharge planner, insufficient communication may result in the patient not completely understanding his or her care plan when they return home and not being compliant with clinical orders regarding diet, exercise, medication, therapy and more.

If the hospital does not have a method for quickly matching patients with post-acute providers and automatically transferring both clinical and psychosocial information—both of which are important facets in a patient's return to health—to post-acute facilities, care lapses can occur. If enough lapses occur, the patient's condition can degenerate, increasing the risk for negative health outcomes and unnecessary hospital readmissions.

For the hospital, flawed discharge handoffs can increase the chance of unplanned adverse events—such as preventable errors—which can give rise to litigation. Moreover, they elevate the risk for unnecessary hospital readmissions and resulting penalties. In addition to the financial ramifications, an inadequate exchange can negatively affect long-term patient health—a hospital's ultimate concern.

What Does a Good Handoff Look Like?

The strongest transitions follow a defined process standardized across the hospital and are integrated with the electronic medical record (EMR). This allows an

organization to be confident that any changeover includes all the necessary elements and is consistent no matter where the handoff takes place.

By using technology integrated with Epic's EMR, hospital discharge planners can automatically extract patient data out of the EMR instead of spending the time to document it again. By sharing standardized packets of patient EMR data with qualified facilities who are part of a no-cost national network, discharge planners are able to quickly and efficiently create a short list of facilities that patients and their families can review and choose from.

Another hallmark of a good discharge handoff is that it starts early—shortly after initial admission, in fact. Depending upon a patient's diagnosis, physicians often know early in the care episode when discharge might occur and what the individual's needs will be at that time. Thus, hospitals should start the discharge process early to ensure plenty of time for disseminating and exchanging information among multiple stakeholders.

Lastly, as with any handoff, the discharge handoff should directly and continuously involve the patient and his or her family. To begin with, hospitals should strive to give patients and families transparency into the referral process and the facility they will go to after they leave the acute-care hospital setting. By providing patients and families with convenient, early bedside access to detailed information about potential post-acute options, discharge planners will have an ally in their efforts to achieve the best possible patient outcomes.

Infusing the discharge handoff process and its various touchpoints with detailed information that addresses patient and family caregiver questions can have a positive impact on future clinical compliance. It can also have a significant impact on a patient's satisfaction with his or her overall healthcare experience.

The Role of Technology in Elevating the Patient Handoff

Taking advantage of discharge planning functionality integrated with an existing EMR plays a critical part in streamlining and standardizing patient transitions. Following are several specific areas where it can have an impact:

- ***Process alerts***. Organizations can create alerts to highlight when critical steps in the handoff process are skipped or not completed. These warnings may be embedded in an organization's electronic health record (EHR) or its discharge planning software.

- ***Patient education***. Hospitals can leverage technology to provide multiple avenues for education, which is critical because patients learn in many ways. For example, a hospital may want to use a tablet for showing videos and walking patients through a care plan. Since good education requires a teach-back component to verify comprehension, the tablet software should offer a method for gauging a patient's understanding and his or her ability to carry out instructions; or to select facilities for post-acute needs.

- ***Care coordination***. This type of technology automates the discharge process, ensuring the hospital performs it consistently and efficiently. Epic's EMR can be integrated with a discharge management solution powered by Ensocare that automates the referral process for case workers and discharge planners.

  In addition, the technology solution helps hospital discharge planners rapidly communicate with post-acute care providers to swiftly generate a potential list for patients to review. Ensocare's solution is backed up by 24/7 customer service center that drives participation and shortens response time of post-acute receiving facilities.

- ***Information transfer***. Technology facilitates virtually instantaneous information exchange between settings, letting organizations share pertinent data. This prevents post-acute providers from having to wait for and sift through the entire medical record, which may or may not happen.

  Instead, post-acute providers can review key information quickly and plan for a patient's care before he or she arrives on site. This means medications aren't interrupted, therapies proceed as planned, follow-up appointments and test occur on time and outside community care resources and providers are primed and ready to contribute to the patient's care.

A New Approach is Necessary

Old methods for guiding discharge—white boards, checklists, printed education materials and post-discharge phone calls—are not as effective as they could be. These

methods occur at a fixed point in time and are subject to the varied practices and styles of the diverse individuals involved. The result is an unreliable discharge experience that does not encompass patient needs and desires now and after they leave the acute-care setting.

To truly improve the reliability of patient discharge handoffs, organizations must commit to defining a process for the transition, standardizing it across the organization and employing the embedded technology solutions they already have at their disposal to support dynamic and responsive information transfer.

[1]*O'Reilly KB. Joint Commission quality initiative reduces poor patient handoffs. http://www.ama-assn.org/amednews/2010/11/01/prsd1104.htm#sthash.X5ifyx3s.dpuf*

Ask About Ensocare's Automated Discharge Solution

Contact us at 877-852-8006 to learn more about Ensocare's automated discharge solution and the benefits it has for your organization, patients and families. Ensocare's automated discharge solution is the ideal way to handle discharge case management, post-acute clinical documentation sharing, direct electronic notifications with your post-acute network and to fully maximize your existing EMR.

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