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TRANSITIONS OF CARE

5 STEPS FOR FIXING
THE MOST DANGEROUS COMMUNICATION PROBLEM IN THE HOSPITAL

White Paper

A recent study led by physicians at the University of Colorado School of Medicine documented what healthcare professionals have suspected for years: that communication breaks down somewhere between hospital discharge and outpatient follow-up. At best, it was unclear who was responsible for post-discharge testing or home healthcare. At worst, primary care physicians didn't know their patients had been admitted at all. [1]

Why is this a problem for hospital administrators? Because nearly 80 percent of serious medical errors involve miscommunications during patient transfers, according to a 2014 article from *Executive Insight*.[2]

> **"NEARLY 80% OF SERIOUS MEDICAL ERRORS INVOLVE MISCOMMUNICATION DURING PATIENT TRANSFERS."**

Successful handoffs—between the hospital and ambulatory setting or even just during shift change—are key target points for efforts to reduce hospital readmissions and measurably improve outcomes. Further, from a patient-satisfaction standpoint, the weeks following hospital discharge may be filled with uncertainty and confusion. Beyond the heightened readmission risk, these crucial weeks may also be fraught with potential to seek treatment from other hospitals or providers.

Administrators are beginning to pin their hopes on patient navigation and transitions of care programs to improve outcomes and keep patients in network. At this early stage, however, strategies and results are all over the map. To help chart a course, we explored the emerging landscape and searched for best practices. These five steps will help you close the most dangerous communication gap in the hospital.

01 Invest in Program Design

Hospitals around the country are experimenting with patient navigation-type programs, but most are limited to one department—cancer centers, for example, are now required to provide patient navigation services in order to earn accreditation by the American College of Surgeons Commission on Cancer.[3] Or, the so-called navigators may simply be discharge coordinators assigned to deliver paperwork and follow-up instructions as patients leave the hospital.

The challenge with these isolated efforts is patient experience. It may make sense from a hospital perspective to navigate by service line, but patients are interacting with the healthcare system via a number of channels, including billing, insurance, ambulatory centers and social services. A recent *New York Times* article revealed that it's not uncommon for four or five different people to contact a patient in the week following discharge.[4] Patients are confused—they may share medication concerns with a billing specialist and assume their physicians have been given the message.

Hospital systems would do well to ask themselves the question posed by the *New York Times:* "Who coordinates the coordinators?" Physicians believe it should be the hospital; the entity with the clinical knowledge should be managing patients across the entire healthcare system.[5] This requires a coordinated effort that takes into consideration reporting structures, communication methods, call schedules, diverse providers, and the needs of various hospital departments. The most successful health systems will take a comprehensive approach, assembling a multidisciplinary team to assess organizational needs and develop a systemwide program.

> **"SUCCESSFULLY MANAGING TRANSITIONS OF CARE REQUIRES CARE TEAMS TO COMMUNICATE IN REAL TIME."**

TIPS FOR SUCCESS

SOLICIT INPUT BROADLY

Consult as many service lines as possible, and allow two to three months for the information-gathering stage. Broad outreach ensures that the needs of diverse hospital departments will be represented by the new system—the subtlest of workflow variances between departments can derail this kind systemwide rollout. Further, early collaboration is essential to guarantee buy-in from the staff members who will ultimately be on the front line making the new system work.

CREATE A CENTRALIZED NAVIGATION DEPARTMENT

Key managers in your organization have to be solely devoted to navigation, maintaining a top-level view across the entire health system while responding to the needs of individual service lines.

IDENTIFY CLEAR, MEASURABLE GOALS FOR THE PROJECT

Be specific about how much you expect to improve patient satisfaction scores and reduce readmissions; be clear about how far out you'll measure patient retention rates. Loosely defined goals are not only difficult to measure, they are ultimately most frustrating for the staff members working to achieve them.

02

Establish Efficient Communication

Successfully managing transitions of care requires care teams to communicate in real time, not through notes in EHRs or messages left with call centers.

As panelists at the 2014 mHealth Summit explored "The Role of mHealth in Coordinated Care," a theme emerged: Smartphone-based communication systems keep all members of a care team in constant contact for improved clinical outcomes, better patient engagement and even higher staff morale. In a pre-conference article in Healthcare IT News, C. William Hanson, MD, CMIO of Penn Medicine, noted that secure messaging apps replace paper handoffs and ensure a secure and effective transfer of care from doctor to nurse and vice versa.[6]

Further, 85 percent of respondents in the first-ever KLAS report on secure messaging reported improved workflow efficiency as a result of the technology. Users preferred sending a discreet text message versus leaving a phone message and waiting for a call-back. Also valuable was the ability to confirm that a message had been received.[7]

TIPS FOR SUCCESS

MAKE IT SECURE

Providers, especially residents, are texting each other anyway—it's the simplest, most direct form of communication in all arenas. Health care administrators can lock it down and protect patient information by offering a secure, HIPAA-compliant messaging system.

IMPLEMENT THE TECHNOLOGY ACROSS THE ENTIRE HEALTH SYSTEM

Early adopters of secure messaging technology often made the mistake of rolling the technology out to physicians only.[8] They quickly discovered that strategy didn't take into account the evolving teamwork approach to practicing medicine. Make sure your patient navigators have access to all members of a patient's care team within the same communication platform. The technology only works if everybody is on it.

INSIST ON INTEGRATED COLLABORATION TOOLS

Basic secure texting functionality will not fully support a complex transitions of care program. Success depends upon care team members having immediate access to on-call physicians, to partner facilities and more. For that, you need robust tools such as physician on-call scheduling, universal contact lists, advanced message escalation and one-touch call-back.

03 Embrace the Private Patient Advocate

In 2007, *U.S. News & World Report* predicted the rise of a new profession: the private patient advocate.

> "The confluence of aging baby boomers with an ever more complex, cost-conscious healthcare system means unlimited demand for a persuasive, persistent person willing to do the vital work of patient advocacy. Some hospitals and HMOs hire nurses and social workers as patient advocates, but there remains a huge unmet need, which may be filled by self-employed advocates."[9]

"I HEAR EVERY DAY FROM ADVOCATES WHO HAVE BEEN BY THE BEDSIDE IN THE HOSPITAL WHO HAVE STOPPED A MEDICATION ERROR."

Trisha Torrey founded The Alliance of Professional Health Advocates[10] in the fall of 2009 with barely 30 members nationwide. By 2016, membership had exploded to more than 600 private patient advocates.

Hospitals were skeptical initially, and physicians were uncomfortable with the idea of having a third party present during patient interactions. Gradually, Torrey says, they are discovering that the addition of a caregiver dedicated solely to one patient benefits the whole system. A patient advocate in the hospital room, for example, can prevent falls, relieve nurses of small tasks, and even safeguard against medical errors.

"I hear every day from advocates who've been by the bedside in the hospital who have stopped a medication error," Torrey notes.

TIPS FOR SUCCESS

ADD THE PRIVATE ADVOCATE INTO THE WORKFLOW

In the ambulatory setting, private advocates help ensure that prescriptions get filled, appointments are scheduled, and home-care regimens are adhered to—provided, of course, that the lines of communication are open between healthcare providers and the advocate.

"We're sitting in the patient's house," notes advocate Linda Adler, CEO of Pathfinders Medical Advocacy & Consulting.[11] "The more we're included in what's being ordered and what needs to be done, the more we can grease the wheel."

MAINTAIN A LIST OF LOCAL PRIVATE ADVOCATES

Patients who can afford to hire their own private advocates ultimately relieve pressure for health systems and free up staff resources that can be utilized for other patients. Helping patient locate these resources is a win-win-win.

04 Provide Supervision & Education

When employing patient navigators to manage transitions of care, supervision is among the greatest challenges. In fact, lack of an appropriate reporting structure could ultimately be the downfall of a program.

As detailed in the Boston Medical Center Patient Navigation Toolkit, patient navigators need both clinical and administrative support.[12] Clinical support, of course, ensures navigators have back-up with patient care as questions arise. Administrative support can be more complicated. Why? Because shift changes and cross-departmental workflow can derail continuity of care. Successful patient navigation depends on patients knowing who to call when they need help. That happens when a multi-department administrator carefully manages call schedules and case loads.

TIPS FOR SUCCESS

IDENTIFY THE CORE SKILLS REQUIRED OF PATIENT NAVIGATORS

Navigation and advocacy spans a wide spectrum—from well-care reminders, to medication assistance and post-discharge guidance, to billing and insurance assistance. Determine what types of advocates your program will be supporting, and then hire and train based on the core skills.

MAINTAIN A TWO-TIERED REPORTING STRUCTURE

Administrative management should oversee all navigators with a birds-eye view of the department and its interaction with the entire health system. Separately, navigators need clinical management by specialty for guidance and training in their service lines.

SEARCH FOR TARGETED EDUCATIONAL OPPORTUNITIES

An emerging field opens new channels for expertise. Along with technical job training, continuing education should include specialized knowledge, such as understanding the top five reasons that patients are readmitted to the hospital within 30 days of discharge.

05 Evaluate & Measure Against Defined Goals

With considerable effort and resources devoted to a transitions of care program, the final step is to make sure the program is working.

Patient satisfaction, hospital readmission rates and time to completion of therapy are metrics health systems are using to evaluate programs. Specific metrics, of course, will depend on the goals set forth when the program was designed.

In crafting the review process, plan for a multilevel approach that includes evaluation of the navigators and the supervisors.[13] Clearly defined expectations, minimum level of core competencies and measurable goals will ensure the program performs across all metrics.

TIPS FOR SUCCESS

GIVE THE PROGRAM TIME TO WORK

A patient navigation system will mostly certainly require workflow shift, and will likely involve some degree of culture change. Don't frustrate your team by measuring results too early. Actual times will vary by size of the organization, but as a rule of thumb, begin looking at metrics six to 12 months from the point where the program has passed the early start-up struggles and feels like it's running smoothly.

CELEBRATE SMALL SUCCESSES

Cost savings and improved outcomes are the ultimate goals, but small improvements are immensely motivational for navigators and managers. Formalize a process for capturing and publicizing positive patient feedback, stories of individual navigator accomplishments and other anecdotal evidence of progress.

LEAVE ROOM FOR IMPROVEMENT

New technologies and processes are emerging all the time that promise to further optimize workflow and improve patient care. Build flexibility into your transitions of care program to allow your team to respond to innovations as they happen in the industry.

References

1. http://www.beckershospitalreview.com/hospital-physician-relationships/study-reveals-communication-breakdown-between-hospital-clinicians-and-pcps.html
2. http://healthcare-executive-insight.advanceweb.com/Web-Extras/Long-Term-Care-Feature/Best-Practices-for-Reducing-Readmissions.aspx
3. http://www.cancer.org/cancer/news/navigators-help-cancer-patients-manage-their-care
4. http://www.nytimes.com/2015/04/14/health/the-tangle-of-coordinated-health-care.html?_r=1
5. Physician interviews
6. http://www.healthcareitnews.com/news/care-coordination-experts-talk-best-worst-practices
7. http://www.klasresearch.com/about-us/press-room/2015/10/06/new-klas-report-gauges-who-leads-the-market-in-secure-messaging
8. https://www.dochalo.com/wp-secure-messaging-adoption
9. http://money.usnews.com/money/careers/articles/2007/12/19/ahead-of-the-curve-patient-advocate
10. Interview with Trisha Torrey, founder, The Alliance of Professional Health Advocates; http://www.aphadvocates.org/
11. Interview with Linda Adler, CEO of Pathfinders Medical Advocacy & Consulting
12. & 13. http://www.avonfoundation.org/assets/bmc-patient-navigation-toolkit-vol-2.pdf

About Doc Halo

Doc Halo's clinical communication platform is transforming patient care by streamlining real-time communication among physicians, nurses and staff. The mobile app and online console provide secure, HIPAA-compliant texting. Robust care coordination tools integrate with hospital systems to allow instant access to EHRs, critical and clinical teams, physician on-call schedules, call centers, labs and directories. Exclusively designed for healthcare, the Doc Halo clinical communication platform is used by several of the most prestigious organizations in the country.

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