Better Outcomes of Children Through Safer Discharge Transitions

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**Background**

1 in 5 discharges experience an adverse event, half of them being preventable. 3/4th of these are medication-related. Direct communication between physicians at discharge occurs in less than 20% of the time. About half of discharged patients unable to state their diagnosis and about a quarter unable to list all their medications.

**General Mission Statement**

To improve the transition of care of patients discharged from WVUCH from general pediatric service

**Aim Statement**

- To improve the PCP appointment rate by 50% in a year
- To improve the patient experience of discharge process to 85 score in PressGaney in a year
- To improve the percentage of patients with handouts to 70% in a year
- To reduce the rate of 30-day readmissions to 6.5%

**Conceptual Model**

**Strategy for change/Leverage Points**

- Checklist as a forcing function
- Role delineation
- EHR implementation
- Handouts
- Teachback
- Workflow integration
- Intent to discharge orderset
- Shared Norming and Group Education
- Webinar with National Coach
- Daily Huddle

**Checklist for early capture of the discharge risk factors and addressing them**

- Early identification of PCP and real-time communication with PCP to optimize transition of care
- Utilizing the EHR for patient resources and handouts
- Scheduling follow-up appointment before discharge will improve discharge process and follow-up compliance
- Post-discharge phone call to families will improve the adherence to discharge instructions and capture errors

**Changes were tested/adapted prior to implementation**

**Results**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction of readiness of discharge</td>
<td>79.7</td>
<td>88.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Patient satisfaction of speed of discharge process</td>
<td>78.9</td>
<td>82.6</td>
<td>0.0008</td>
</tr>
<tr>
<td>Patient satisfaction of discharge instructions</td>
<td>79.7</td>
<td>88.6</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Handouts</td>
<td>18</td>
<td>77</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Patient Appointments</td>
<td>33</td>
<td>71</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>30d Readmissions</td>
<td>8.4</td>
<td>7.7</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Lessons Learned**

- Change management and Human Factors
- Role Delineation
- Simplification of the checklist
- Integrating into Workflow

**Multidisciplinary Team**

- **Coach**: External and Local Mentor
- **Members**: Pharmacist, Hospitalists, Social Worker, Care Manager
- **Data Analysis**: Zheng Dai, Savanna Plombon, Chizite Iheonunekwu
- **Sponsor**: WVCTSI, Center of Quality Outcomes