Improving Transitional Care

The role of handoffs and discharge checklists in hematologic malignancies

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BACKGROUND: Transitional care from inpatient to outpatient settings is a high-risk time for medical errors and missed follow-up appointments. Discharge checklists and handoffs are effective tools that lead to improved quality of care and outcomes.

OBJECTIVES: The purpose of this project was to implement an evidence-based discharge checklist and handoff template to improve and standardize transitional care from hospital to home for patients with hematologic malignancies.

METHODS: The advanced practice providers (APPs) completed the discharge checklist at least 24 hours prior to discharge. The APPs requested appointments through the electronic health record using the discharge handoff tool. Chi-square analysis and descriptive statistics were used to analyze the data.

FINDINGS: Implementation of the discharge checklist resulted in a statistically significant increase in the number of patients who had a follow-up appointment scheduled prior to discharge. The discharge handoff tool standardized communication between inpatient and outpatient providers.

PATIENTS WITH HEMATOLOGIC MALIGNANCIES ARE FREQUENTLY HOSPITALIZED for cancer treatment, oncologic emergencies, disease progression, and complications and adverse effects from chemotherapy. Many of these patients require meticulous, coordinated follow-up after they are discharged from hospital to home. Patients receiving aggressive chemotherapy, for example, can develop low blood counts that require ongoing laboratory monitoring, blood and platelet transfusions, and administration of granulocyte–colony-stimulating factor (G-CSF) to increase production of white blood cells (National Cancer Institute, 2018; Warsame et al., 2016). Effective transitional care is critical to ensuring these patients receive optimal health care as they move from inpatient to outpatient settings.

Transitional care encompasses a range of actions designed to provide continuity and coordination of health care during a patient's transfer from one location of level of care to another (Coller et al., 2017). However, medical errors, adverse events, communication lapses, care coordination failures, and medication errors frequently occur during this period (Payne, Stein, Leong, & Dressier, 2012; Warsame et al., 2016). Inadequate transitional care leads to fragmented patient care, patient dissatisfaction, and hospital readmissions, which cost Medicare an estimated $17 billion per year (Mansukhani, Bridgeman, Candelario, & Eckert, 2015; Mora, Dorrejo, Carreon, & Butt, 2017).

Communication among healthcare providers is often delayed and lacks essential information, leading to inefficient transitional care and delays in care (Mallory et al., 2017). Hospital discharge summaries—one of the primary means of communication among inpatient and outpatient healthcare providers—often lack important information, such as discharge diagnoses, a review of inpatient episodes of the plan of care, diagnostic test results, discharge medications, and follow-up plans (Gao et al., 2018; Moy et al., 2014). As a result, discharge summaries can create patient safety issues because incomplete and untimely communication leads to increased risk for hospital readmission (Mehta et al., 2017). In addition, ineffective handoff among healthcare providers causes delays in treatment and discontinuity in care that negatively affects patients (Moy et al., 2014). For example, according to McLeod (2013), about 50% of hospitalized patients experience at least one medical error during transitional care because of communication failures among healthcare providers.

The hematologic malignancies nursing unit at Duke University Hospital did not have a standard discharge process for safe transitional care. Lack of standardization resulted in discontinuity of care, including no appointments scheduled for follow-up with oncologists, laboratory monitoring, or G-CSF administration. Unsigned orders for G-CSF and incorrect dates for G-CSF administration in the treatment plan prompted healthcare provider interruptions to correct the orders and delayed patients from receiving G-CSF in the outpatient cancer treatment center. Because of a lack of handoff procedures, outpatient healthcare providers relied on the electronic health record (EHR) to review the patient's inpatient course of care. Reliance on the EHR was problematic because the EHR is designed to record individual encounters, not to coordinate longitudinal care across settings (Tyler et al., 2014).

The purpose of this project was to implement an evidenced-based discharge checklist and handoff tool to improve and standardize transitional care from hospital to home for patients with hematologic malignancies. The specific objectives were as follows:

- Implement an evidence-based discharge checklist to increase the number of patients who have follow-up and laboratory monitoring appointments scheduled at least 24 hours prior to discharge.
- Implement an evidence-based discharge checklist to increase the number of patients who have signed orders and appointments for G-CSF scheduled at least 24 hours prior to discharge.
- Implement an evidence-based discharge handoff tool to standardize and increase communication from inpatient to outpatient healthcare providers at least 48 hours prior to discharge.

Literature Review

International guidelines indicate that checklists are a key measure in the prevention of medical errors (Khanbhai, Nance, & Smith, 2018). Checklists are critical to safe transitional care because they augment often-overlooked steps in the discharge process and serve as cognitive aids for healthcare providers, leading to improvements in patient safety and quality of care (Garg, Lee, Evans, Chen, & Shieh, 2015; Grigg, 2015; Khanbhai et al., 2018; Soong et al., 2013). A discharge checklist includes discharge tasks that inpatient healthcare providers complete before the patient leaves the hospital. In 2016, the Mayo Clinic conducted the only study specific to the discharge needs of patients with hematologic malignancies. Study results showed that development and implementation of a discharge checklist led to a demonstrable increase in the number of patients who received appropriate discharge follow-up (Warsame et al., 2016). Discharge handoff tools are also important in ensuring continuity of transitional care because they facilitate communication between inpatient and outpatient healthcare providers (Lenert, Sakaguchi, & Weir, 2014). Moy et al. (2014) created an inpatient-to-outpatient discharge handoff tool that included expected discharge date, admission diagnosis, follow-up appointments, pending tests at discharge, pertinent

"Ineffective handoff among healthcare providers causes delays in treatment and discontinuity in care."

information, and homecare services arranged. Use of this handoff tool significantly improved communication among healthcare providers, resulting in more handoff notes in the EHR within 24 hours of discharge compared to discharge summaries alone (Moy et al., 2014). Clinicians attending the Transitions of Care Consensus Conference (TOCCC) proposed that the transition record includes the patient's principle diagnosis and problem lists, medication lists, test results/pending results, and treatment/diagnostic plan. The TOCCC also recommended that healthcare institutions develop standardized data transfer forms, such as tools and transmission protocols (Snow et al., 2009).

Methods

This project was implemented in a 31-bed hematologic malignancies nursing unit at Duke University Hospital, a nonprofit, tertiary, level one trauma and academic medical center in North Carolina consisting of 957 beds. On average, there are one to four discharges from the nursing unit per day.

Patient Population

The patient population consisted of adults aged 18 years or older who were hospitalized with a hematologic malignancy, primarily leukemia, lymphoma, multiple myeloma, and myelodysplastic syndromes. Patients with hematologic malignancies discharged from the nursing unit were included in the study. Patients who died, were discharged to hospice, did not have a hematologic malignancy, left against medical advice, or did not receive care on the hematologic malignancies nursing unit were excluded. The second population for this project was the advanced practice providers (APPs) who worked on the hematologic malignancies nursing unit. Five APPs (four nurse practitioners and one physician assistant) participated. This quality improvement project was formally evaluated using a quality improvement checklist and determined not to be human subject research.

Development of Discharge Checklist and Handoff Tool

To understand the current discharge process at the academic medical center, the authors conducted one-on-one interviews

with two inpatient APPs, one outpatient APP, the nurse manager, and the case manager. The Failures Modes and Effect Analysis (FMEA) was incorporated into the interviews because it provided a systematic method of evaluating a process, assessing risks of failure and harm, and identifying key areas of process improvement (Institute for Healthcare Improvement, 2017). Use of FMEA allowed the authors to better understand current discharge practices, identify where and how failures occurred, and assess the effect of these failures on patients. Common problems noted during the interviews were as follows:

- Follow-up appointments were frequently scheduled after patient discharge.
- G-CSF orders were not signed prior to patient discharge.

- Outpatient providers received less than 24 hours notification of patient discharge.
- Communication among inpatient and outpatient providers were inadequate.

The study coordinator used this information, along with the Mayo Clinic discharge checklist (Warsame et al., 2016), to create a discharge checklist that was applicable to this project's clinical setting (see Figure 1).

The discharge handoff tool for this clinical setting (see Figure 2) was adapted from TOCCC recommendations (Snow et al., 2009), the discharge handoff tool created by Moy et al. (2014), and information the APPs considered critical to safe transitional care. The study coordinator created a smart phrase for the handoff

FIGURE 1.

HEMATOLOGIC MALIGNANCIES DISCHARGE CHECKLIST

PATIENT NAME: _____

DISCHARGE DATE: _____

PHYSICIAN NAME: _____

QUESTION	RESPONSE	
Follow-up		
Does patient have follow-up appointment?	☐ Yes	☐ No
When does the patient need to be seen?		
Laboratory monitoring		
Are patient's counts recovered/stable? (If yes, disregard remainder of section.)	☐ Yes	☐ No
Does patient have primary oncologist?	☐ Yes	☐ No
How often does patient need laboratories?		
Was a local oncologist referral placed?	☐ Yes	☐ No
Is there communication with a case manager?	☐ Yes	☐ No
Bone marrow transplantation clinic		
Does patient require this clinic? (If N/I, disregard remainder of section.)	☐ Yes	☐ N/I
Is there communication with the charge nurse?	☐ Yes	☐ No
Did the provider call report?	☐ Yes	☐ No
Home health		
Is home health required? (If N/I, disregard remainder of section.)	☐ Yes	☐ N/I
Was a referral placed?	☐ Yes	☐ No

QUESTION	RESPONSE	
Significant medications		
Does patient take prophylactic antimicrobials?	☐ Yes	☐ No
Does patient have prior authorization for new medications?	☐ Yes	☐ N/I
Is there communication with the case manager?	☐ Yes	☐ No
Does patient take oral chemotherapy?	☐ Yes	☐ N/I
Was the order placed by the attending physician?	☐ Yes	☐ No
Does patient have the medication?	☐ Yes	☐ No
Is outpatient chemotherapy scheduled?	☐ Yes ☐ N/I	☐ No
Growth factor support		
Is growth factor support required? (If N/I, disregard remainder of section.)	☐ Yes	☐ N/I
When is it scheduled?		
Where is it scheduled?		
Is the appointment scheduled with an appropriate amount of time?	☐ Yes	☐ No
Does the order have correct administration date, and is it signed?	☐ Yes	☐ No

N/I—not indicated

tool. This smart phrase, which created a charting shortcut within the EHR (UC Davis Health System, 2013), allowed providers to easily access the handoff tool by typing a short phrase. Meetings were held with the study coordinator, inpatient APPs, and nurse manager to discuss the implementation plan for the discharge checklist and discharge handoff tool. Because the APPs were responsible for coordinating patient discharge and follow-up needs, they completed the discharge checklists. The study coordinator provided the APPs with one-on-one training regarding when to complete the discharge checklist and handoff tool and how to access the tool using the smart phrase.

Discharge Procedures

The discharge checklist and discharge handoff tool were implemented in October 2017. The APPs completed the discharge checklist at least 24 hours prior to the patient's discharge.

During morning team rounds, healthcare providers discussed the met and unmet needs of patients being discharged within the next 24–48 hours. The study coordinator placed folders, labeled with the days of the week, in the team workroom. The APPs filed the completed checklists in the folders corresponding to each patient's anticipated day of discharge.

The APPs used the discharge handoff tool to request follow-up and laboratory monitoring appointments through the EHR's in-basket messaging system. Messages were sent to the patient's primary oncologist, the outpatient APP, and the scheduling team. Outpatient providers must approve an appointment before it can

be scheduled, which takes about 48 hours. Therefore, the goal was for inpatient APPs to send appointment requests at least 48 hours prior to patient discharge to increase the chances of appointments being scheduled prior to discharge.

Data Collection and Analysis

Preimplementation data was collected from April to August 2017, and post data from November 2017 to February 2018. To assess the number of patients who had follow-up, laboratory monitoring, and G-CSF appointments scheduled at least 24 hours prior to discharge, the authors conducted retrospective chart reviews using the EHR's scheduling board, as well as reviews of the after-visit summary (AVS), a document listing follow-up appointments that is provided to patients at discharge. Ambulatory referrals were also reviewed to assess whether referrals to a local oncologist for laboratory monitoring and G-CSF administration were ordered at least 24 hours prior to discharge. The EHR's oncology springboard, which contains a patient's current and previous chemotherapy treatment plans, was examined to determine whether a G-CSF order was signed prior to discharge and if the correct administration date was included in the treatment plan.

To assess if the APPs used the discharge handoff tool and if they sent appointment requests at least 48 hours prior to patient discharge, the authors conducted retrospective reviews of the EHR's in-basket messaging system.

The study coordinator used a secured, encrypted laptop to enter the pre- and postimplementation data into a Microsoft Excel® spreadsheet. IBM SPSS Statistics, version 24.0, was then used to analyze the data.

Results

Data comparing pre- and postimplementation groups are presented in Table 1. To determine if implementation of the discharge checklist led to an increase in the number of patients who had follow-up and laboratory monitoring appointments scheduled at least 24 hours prior to discharge, the authors performed chi-square analyses using data from the EHR scheduling board, the AVS, and ambulatory referrals. A statistically significant difference was noted in the percentage of scheduled follow-up appointments (χ^2 [2, N = 159] = 18.89, p < 0.001). The number of patients who did not have a follow-up appointment scheduled within 24 hours of discharge decreased from 42% to 25% after implementation of the discharge checklist. A statistically significant difference was noted in local oncologist ambulatory referrals (χ^2 [1, N = 107] = 8.73, p = 0.003). After the discharge checklist was implemented, ambulatory referrals ordered within 24 hours of patient discharge for supportive care with local oncologists increased from 73% to 92%. There was a statistically significant difference in the number of scheduled follow-up appointments listed on patients' AVS (χ^2 [2, N = 89] = 39.34, p < 0.001). The

FIGURE 2.
DISCHARGE HANDOFF TOOL

ITEM	RESPONSE
Patient date of discharge	
Primary admission diagnosis	
Chemotherapy regimen and day in current cycle	
Blood counts	
Significant events during admission	
Significant new medications (i.e., chemotherapy and antimicrobials)	
Local oncology services that have been arranged	
Homecare services that have been arranged	
Recommendations for follow-up	

TABLE 1.

COMPARISON OF PRE- AND POSTIMPLEMENTATION GROUPS REGARDING DISCHARGE NEEDS

| OUTCOME | PREIMPLEMENTATION (N = 232) | | | | | | POSTIMPLEMENTATION (N = 296) | | | | | | p |
| | YES | | NO | | APPOINTMENT BEFORE ADMISSION | | YES | | NO | | APPOINTMENT BEFORE ADMISSION | | |
	n	%	n	%	n	%	n	%	n	%	n	%	
Follow-up appointment	47	22	91	42	77	36	67	24	68	25	143	51	0.001
Laboratory monitoring	85	39	67	30	69	31	98	34	67	23	126	43	0.017
Ambulatory referral to local oncologist	35	73	13	27	–	–	72	92	6	8	–	–	0.003
Appointment on AVS	78	34	63	27	90	39	88	30	26	9	181	61	0.001
G-CSF order	70	79	18	20	–	–	90	95	5	5	–	–	0.005
G-CSF appointment	57	63	10	11	23	26	56	60	6	6	32	34	0.302

AVS—after-visit summary; G-CSF—granulocyte–colony-stimulating factor
Note. Because of rounding, percentages may not total 100. In addition, n values may not add up to the total N because not all discharge requirements were applicable to every patient. The data analyses only included patients who required those discharge needs.

number of patients who discharged without a scheduled follow-up appointment at discharge decreased from 27% to 9%.

To determine if implementation of the discharge checklist led to an increase in the number of patients who had signed orders and appointments for G-CSF scheduled at least 24 hours prior to discharge, the authors performed chi-square analyses using data from ambulatory referrals, the AVS, and the EHR's scheduling board and oncology springboard. A statistically significant difference was noted in G-CSF orders (χ^2 [2, N = 160] = 16.65, p = 0.005). After the discharge checklist was implemented, the number of signed G-CSF orders that included the correct administration date in the treatment plan increased from 79% to 95%.

To determine if implementation of the discharge handoff tool led to an increase in communication from inpatient to outpatient healthcare providers at least 48 hours prior to discharge, the authors performed chi-square analyses using data from the EHR's in-basket messaging system. A statistically significant difference was noted in the number of in-basket messages sent at least 48 hours prior to patient discharge (χ^2 [2, N = 112] = 26.3, p < 0.001). The number of appointment requests sent at least 48 hours prior to patient discharge increased from 22% to 49%.

The authors used descriptive statistics to measure compliance to implementation of the discharge checklist and handoff tool. During the four-month implementation phase, the APPs completed a discharge checklist on 65% of patients discharged from the hematologic malignancy nursing unit. The APPs used the

discharge handoff tool 76% of the time when requesting follow-up appointments through the EHR's in-basket messaging system.

Discussion

This quality improvement project implemented an evidence-based discharge checklist and handoff tool to improve and standardize transitional care from inpatient to outpatient for patients with hematologic malignancies. All but two outcomes—G-CSF and laboratory monitoring appointments—showed significant improvement after implementation of the discharge checklist and handoff tool. Use of the discharge checklist led to an increase in the number of patients whose discharge needs were met at least 24 hours prior to discharge, and use of the handoff tool led to an increase in the number of EHR in-basket messages sent to outpatient healthcare providers at least 48 hours prior to patient discharge.

No significant decrease was noted in the number of patients who did not have G-CSF and laboratory monitoring appointments scheduled at least 24 hours prior to discharge. Several factors likely contributed to this result. During the holiday season, laboratory monitoring and G-CSF appointments in the outpatient cancer treatment center required approval by the nurse manager, which caused a delay in scheduling appointments. Also, in the postimplementation group, more patients had laboratory monitoring appointments scheduled prior to admission, so fewer patients needed the APPs to request appointments. In

addition, in the preimplementation group, only 10 of 90 patients did not have a G-CSF appointment scheduled at least 24 hours prior to discharge. Although the healthcare providers who were interviewed by the authors initially perceived a lack of G-CSF appointments to be an issue, these findings suggest that it was not a significant problem.

Although the reduction in the number of patients who did not have G-CSF and laboratory monitoring appointments scheduled at least 24 hours prior to discharge was not statistically significant, it was clinically significant because G-CSF administration is prophylaxis for chemotherapy-induced neutropenia (Cetean et al., 2015). In patients with hematologic malignancies, neutropenia and neutropenic complications contribute to high mortality rates of 20%, and the highest average hospitalization costs of $52,579 (Schilling, Parks, & Deeter, 2011). Patients with hematologic malignancies also develop low hemoglobin and platelet counts after receiving aggressive chemotherapy. Therefore, the scheduling of laboratory monitoring appointments facilitates timely laboratory draws and results. These timely laboratory results prompt providers to order outpatient blood and platelet transfusions, if needed.

Adoption of the discharge checklist (65%) was lower than adoption of the discharge handoff tool (76%). Lower compliance can be attributed to several factors. The APPs were short-staffed during the implementation of the project, and they often perceived the checklist as burdensome. In addition, the checklist was not integrated into the APP clinical workflow. Incorporating the discharge checklist into the EHR could increase adoption because providers are more likely to integrate an EHR checklist into their workflow than they are a paper checklist (Garg et al., 2015).

Limitations

Although this project had positive results, it had several limitations. The project focused only on transitional care from inpatient to outpatient healthcare settings; it did not examine transitions of care within healthcare settings. In addition, bedside nurses were not included in the implementation of the new discharge process. Finally, the discharge checklist and handoff tool were designed to meet the needs of patients in a particular academic medical center; these tools may be modified for use in other settings.

Implications for Practice

Nurses are key to the successful adoption of discharge checklist and handoff tools. Because nurses review the AVS with patients, they serve as gatekeepers to transitional care and are critical to ensuring an effective discharge process. Oncology nurse navigators are also important to safe inpatient-to-outpatient transitions because they coordinate patient-centered care across healthcare settings (Oncology Nursing Society, 2018). Other studies have recognized the importance of nurses during the

IMPLICATIONS FOR PRACTICE
- Assess patients' discharge needs prior to the day of discharge to increase the chances that patients' needs are met before they are discharged from the hospital.
- Use a discharge checklist to minimize the risk of discharging patients without addressing all needs.
- Ensure that healthcare providers communicate pertinent information about the patient's hospital course through the use of a discharge handoff tool.

inpatient-to-outpatient transition. Gao et al. (2018) implemented a discharge timeout where, on the day of discharge, the nurse and healthcare provider convened with the patient to complete the checklist. Drake, McBride, Bergin, Vandeweerd, and Higgins (2017) implemented a pause on the day of discharge, during which two nurses reviewed the checklist to ensure all components had been addressed prior to discharge. These studies reinforce the significant role that nurses play in the adoption of discharge checklists, which were shown to improve patient safety by eliminating errors during the discharge process.

Conclusion

Similar to the study conducted by the Mayo Clinic (Warsame et al., 2016), the current study developed a discharge process designed to meet the needs of patients with hematologic malignancies in the authors' practice setting. Because transitional care must be tailored to individualized settings (Warsame et al., 2016), the discharge checklist and handoff tool can be adapted to suit each healthcare facility's specific needs. The discharge checklist and handoff tool provided organization and standardization that resulted in improved provider communication and increased scheduling of follow-up appointments that are critical to patient safety. This quality improvement project demonstrated that use of a discharge checklist and handoff tool significantly improves inpatient-to-outpatient transitional care for this patient population. Continued research on transitional care for patients with hematologic malignancies is needed to ensure this population's complex discharge needs are thoroughly understood and addressed.

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