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, & Dressler, 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.