



Transitions of Care: Investigating Patient experience in the Transition from Inpatient Hospitalization to Outpatient Follow-up.

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Introduction

- The role of the primary care physician (PCP) has changed substantially in the last 20 years. Traditionally, primary care physicians were able to provide the greatest continuity of care because they admitted their own patients to the hospital and would then follow up with them in an outpatient setting
- However, the new age of primary care gives providers the opportunity to focus in either an inpatient (as a hospitalist) or outpatient (as a general practitioner) setting.
- Intrinsic to this change in the function of the primary care provider is a discontinuity of care that naturally arises when there are changes in providers over the course of a patient's illness.
- As primary care providers choose a role in inpatient or outpatient medicine the communication that occurs as patient's transition from these respective places becomes a crucial part in providing quality care
- Delays and absence of appropriate communication between providers has a negative impact on patient care leading to increased medical errors and higher hospital recidivism.



Background

- Perhaps the greatest tool of communication between hospitalists and general practitioners is the discharge summary. Unfortunately, there is no universal standardization for content or delivery of discharge summaries. This lack of standardization leads to two major problems: lack of appropriate information conveyed in the summaries and an increased length of time from patient discharge from the hospital to delivery of discharge summary to the GP.³
- Delays and absence of appropriate communication between providers has a negative impact on patient care. A 2007 review in the Journal of Hospital Medicine states that nearly half of patients experience a medical error at the time of discharge and that approximately 19-23 % of patients experience a bad outcome as a result of an error.³
- There are many factors that contribute to these errors. In terms of communication between physicians, there are deficits that occur both as a patient is entering and leaving a hospital. Many outpatient providers are rarely notified when their patients have been hospitalized. Therefore, they are not able to provide hospitalist pertinent medical information that could be used to assist the creation of the patients care plan. Furthermore, many GP's often hear of a patient's hospitalization when the patient shows up for a follow up appointment. ^{1,3,56}
- In terms of communication between patients and physicians, the education and information given to patients at the time of discharge is often inadequate- patients leave without a clear understanding of reasons behind their hospitalizations, medication changes, and follow-up instructions. Perhaps one of the greatest barriers to proper communication is patient understanding. Providers often overlook a patient's education level, and may provide information at a level that is inaccessible and thus useless to the patient. ^{1,3,5-6}
- With all of these things in mind, the aim of this study is to identify problems in the transition from inpatient to outpatient management and to investigate the impact of demographic differences in this transition.

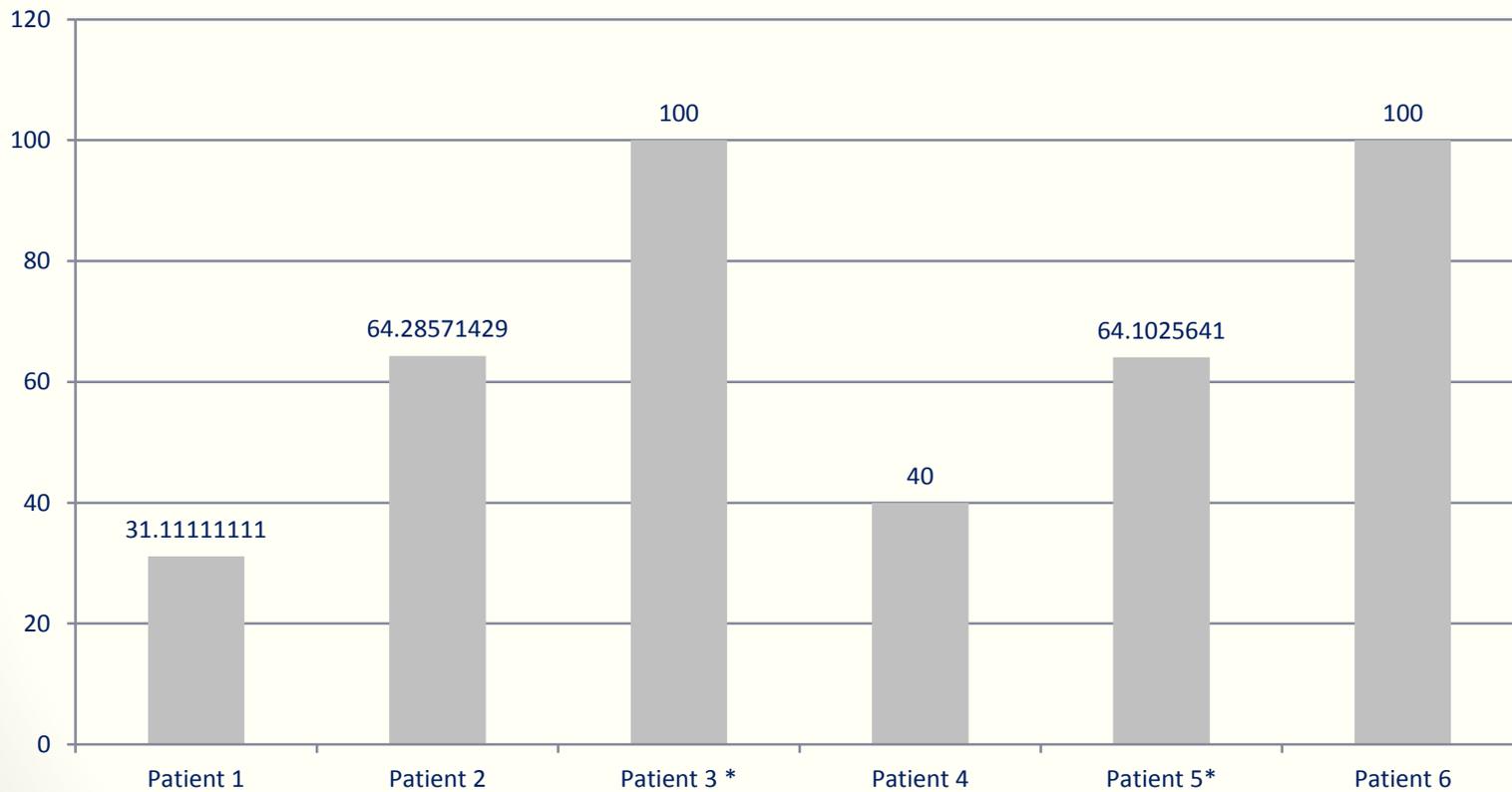


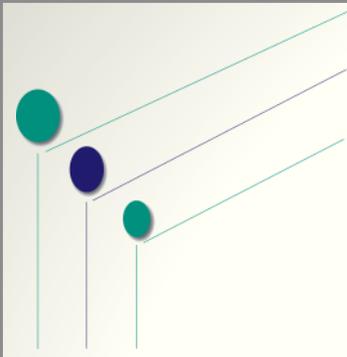
Methodology

- Patients recently discharged after hospitalization were given a 15 question survey (CTM-15) that addressed various issues that arise as patient's transition from inpatient to outpatient healthcare services.
- The Care Transition Measure (CTM-15) survey was developed by the division of health care policy and research at University of Colorado. Each question in the survey had a 4-point response scale: strongly agree; agree; disagree; and strongly disagree.
- The 15 items were treated as one-dimensional measure and simple mean scores (1-4) on answered items were calculated for each patient and converted with a linear transformation to a 0-100 scale with the lowest possible score being zero and the highest possible score being 100. The higher the score the better the quality of the care transition.⁷
- In addition to the 15 question survey, I wanted to assess the method and timeline for receiving a discharge summary in the Centro-Med clinic. I asked that each nurse look through the chart and find out if the discharge summary was available for the GP at the time of the follow up appointment and if so, how the discharge summary was delivered to the GP

Results

CTM scores by patient





Results

Patient 1	Did not bring discharge summary to follow up visit- physician had access to hospital Electronic medical record
Patient 2	Brought Discharge summary to follow up visit
Patient 3	Brought Discharge summary to follow up visit
Patient 4	Brought Discharge summary to follow up visit
Patient 5	Brought Discharge summary to follow up visit
Patient 6	Brought Discharge summary to follow up visit



Discussion

- There was no statistically significant difference in CTM scores for non-English speaking patients.
- There was no statistically significant difference in CTM scores based on age.
- There was a disproportionate number of men and women, but on average men were more likely to have higher CTM scores than women.

LIMITATIONS:

- The power of this study was extremely limited by the sample size. I think that a big part of the problem regarding finding eligible patients to participate in the study had to do with the fact that the clinic served a large HIV+ population in San Antonio. Many of the patients came in strictly for their HIV related follow up appointments. There were a very limited number of patients with general primary care problems—chronic diseases that lead to acute exacerbations and hospitalization.
- Because of this limitation, I believe that the result of my study severely underestimates the problems that patients face as they leave the hospital.

FUTURE RECCOMENDATIONS

- In the future I think that if I were to revisit this topic, I would extend the period to collect surveys in order to get a bigger sample size. I would also ask more specific demographic questions such as level of education received, diagnosis related to hospitalization, and I would keep track of specific hospitals that patients were admitted to.



Recommendations

- In the original literature regarding use of the CTM survey, they found that answering negatively to certain questions in the survey were markers for long-term recidivism.⁷
- I think that questionnaires like the CTM-15 if more heavily tested could be used in an inpatient setting to help identify patients at risk for re-hospitalization. Low scores on CTM-15 could prompt a provider to use extra resources to ensure that a patient understands the important aspects of their hospital course, medication changes, and follow up plan.



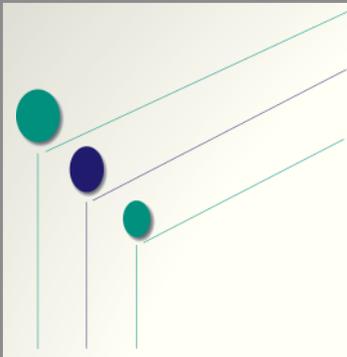
Conclusion

- The widespread use of the electronic medical record has made standardization of documentation through the use of templates, data extraction (lab values, imaging etc.) and exchange of information between physicians much easier.
- Though this use of technology is a step in the right direction, there are still strides to be made in the area of transitions of care in the field of medicine.
- One thing that struck me both in the literature regarding transitions of care, as well as in my own experiences, is that the communication that occurs between provider and patient is one of the most important factors that affect patient outcomes. It is also an area that each provider can individually focus on in order to create better outcomes for patients as they transition from one setting to another.
- With health care reform slated to expand the number of community health centers, and the lower education levels inherent in the socioeconomically disadvantaged population served by these CHC's. We must do more to promote better communication. This requires being in tune with the education level of the patient, and creating inventive strategies of delivering information in a way that can be both simply understood by patients, and encouraging for them.



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