Improving Care Transitions Requires Aligned Teamwork

Optimizing patient flow is essential for improving care transitions, and while it's a focus in every hospital, its level of coordination and effectiveness varies widely. What if instead, care transitions could be coordinated and disciplined, with everyone moving in sync?

Driving home from work on a cloudless fall day, John's sedan is rear-ended on the highway by a pickup truck traveling 90 mph. Critically injured, John is taken to the nearest trauma center, where he's diagnosed with brain trauma and an intracranial hemorrhage. After John's cranial swelling lessens, he's transported to a specialty health center for successful decompression surgery. Eight days of intensive care and six figures in medical bills later, he's ready for discharge to a lower-tier care facility.

Suddenly, John's care starts to hit roadblocks. An admissions surge at the hospital nearest John's home delays his transfer, and now his care team is struggling to place him at an appropriate skilled nursing facility for recovery. So begins a complex, time-consuming flurry of faxes, e-mails and calls on John's behalf, captured in a variety of

disconnected systems. Meantime, John remains in his costly post-surgical hospital bed while another patient with higher acuity awaits admission.

Multiply John's care transition issues by thousands each day and you get an idea of the scope and scale of care transition challenges in healthcare. Optimizing patient flow is essential for improving care transitions, and while it is a focus in every hospital, its level of coordination and effectiveness varies widely.

Complex Care Transitions

Let's consider how this complex coordination of transitions plays out in practice. Even in today's high-tech era, patient care information still flows through faxes, emails and phone calls—typically through multiple systems and engaging several people, service lines, departments and organizations. When any information is missing, needs clarifying or requires updating, a seemingly simple request for detail typically means repeating each step, with an inbox stop at each step. On nights and weekends, information exchanges can move even slower (or not at all) due to lower staffing.

Millions of dollars in staff time and patient expenses are wasted daily while this chaotic scramble repeatedly happens. Clinicians and other staff heroically struggle to get patients to the right places for the right care at the right time, but they're up against problematic systems and processes.

What if, instead of this daily mess, care transitions could be coordinated and disciplined, with everyone moving in sync, like a well-choreographed ballet?

Address Connection Points

Complex systems and processes, like those managing care transitions, invariably fail at connections. Compare to what's required for a car to stay on the road, with hands connected to tires through myriad connections working in concert: steering wheel, upper column, universal joint, pinion, tie rods, wheels and finally tires. Obviously, it would be problematic if any of these parts weren't compatible, or if they didn't work on nights or weekends. We wouldn't accept such a car.

Over time, health care processes have evolved independently, with new technologies implemented, new roles created and new networks and partnerships formed. Each part within the larger system will typically optimize its own local processes, unaware of impact to the whole process. Siloed care transition processes can lead to incompatible software, notes written according to personal preferences and changes implemented without regard to broader impact. The result? Reduced quality, higher costs, frustrated patients and staff and delays between steps.

To make care transitions more like a synchronized ballet, we need to ensure reliable connections between each step. The critical first step is gaining a bigger-picture perspective. One effective tactic is to use value stream

mapping to help all involved literally see and understand the process flow from beginning to end and across all connections. With each process step and connection mapped, issues between steps become more obvious.

Mapping out complex care transitions highlights frustrating transition issues that can lead to quality issues wasting time and money. It also reveals improvement opportunities. Consider the example of a health care facility that sought to reduce missing or unclear information sent from the emergency room to patient logistics. By electronically standardizing information needed by all team members, this eliminated the need for additional information requests, and ensuing delays.

Similarly, members of a multidisciplinary team at an academic medical center conceived of a simple way to ensure patients had a safe ride home, expediting discharge and freeing up costly inpatient beds. The solution? The medical center contracted with a local transport company to give patients a ride home. Spending an average of less than $20 per ride, the medical center immediately achieved positive benefits. Patients received timely discharges, capacity was freed for another patient's care and reimbursements resumed for inpatient rooms.

Collaborative Teams/Smoother Connections

Involving process participants from each team is critical to creating reliable connections. Cross-functional teams need a common understanding of the overall process and the impact of their roles to create more reliable, time-saving connections. It's impossible to know where to improve connections without involving all teams.

Changing processes someone else has created and done for many years can be met with resistance. Involving the team members in process mapping and analyzing helps everyone see the potential for process improvements. Empowering staff to design these changes gives them ownership of the new process. Involvement and empowerment help overcome resistance.

In health care, connections often span organizations, adding complexity and further isolating teams involved in a single process. Engaging teams across organizations can significantly reduce transition challenges. For example, if an SNF doesn't accept patient transfers on weekends, this may cause up to a three-day delay in patient transfers. Consider instead a medical center partnering with designated SNFs to align on a goal to reduce transfer wait times. Improvements can be incentivized through cost-sharing contracts, resulting in savings for the entire system. Working collaboratively, a multi-day weekend transfer process can reliably become same-day!

Bottom-line, the key to improving complex systems like care transitions is aligning around a purpose of optimizing patient flow through the entire system, identifying and resolving pain points and working collaboratively toward achieving the desired outcome. The best solution for any given organization will depend on the expertise and perspective of the teams involved, and their willingness to move beyond traditional silos.