Uncovering Errors in Transitions from Hospital to Nursing Home: A Video Telehealth Transitions Conference

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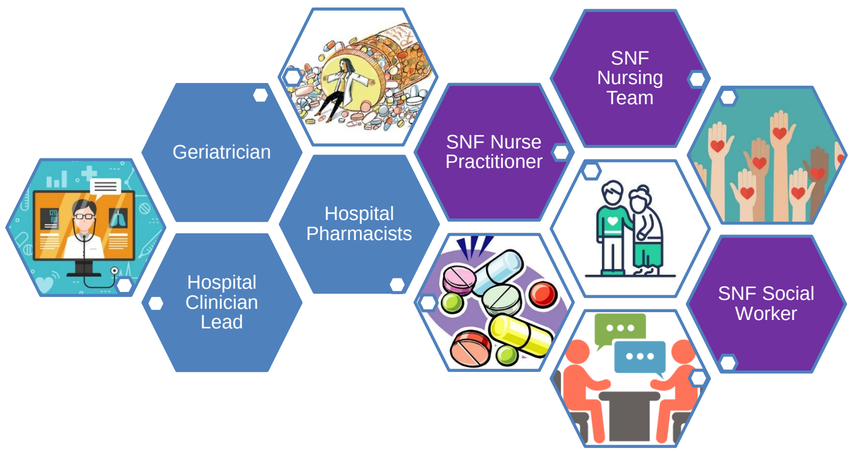
BACKGROUND

- Transitions across healthcare settings lead to unintentional errors, rehospitalizations, and mortality.
- A leading cause is poor communication between care settings.

INTERVENTION

A weekly telehealth videoconference to facilitate a virtual care conference meeting between hospital-based and skilled nursing facility (SNF) provider teams to optimize error-prone transitions.



PROJECT AIM

To evaluate the care transition errors identified during videoconferences through the multi-disciplinary review and discussion of cases.

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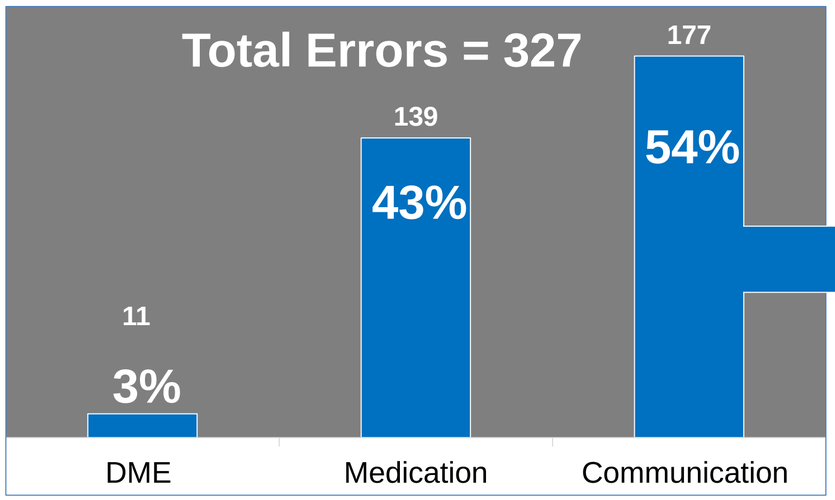
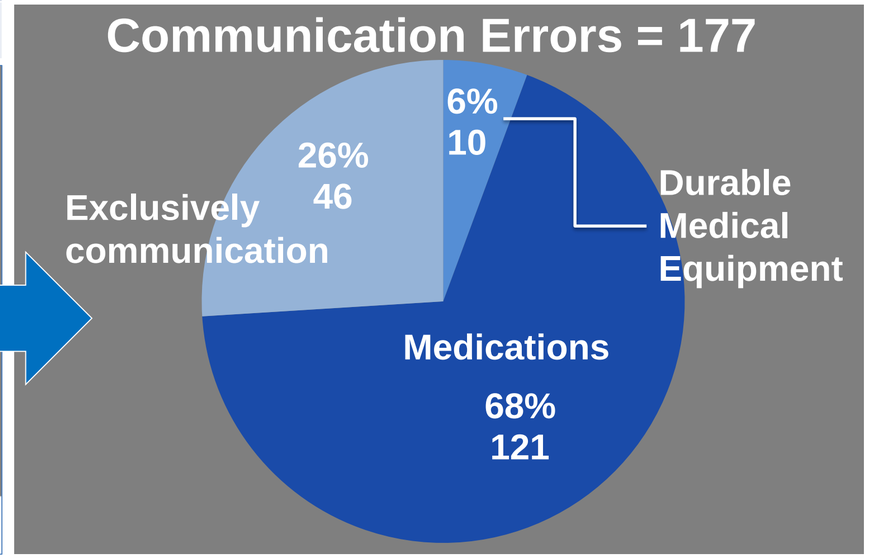
OUTCOMES

Demographics of patients who qualified for post-acute care and received telehealth intervention between July 2019 – Jan 2020	
Total Patients	n=290
Duke University Patients	63%
Duke Regional Hospital Patients	37%
Age at Discharge, mean	77.5 years
Sex (female)	58%
Hospital Length of Stay, median	6.6 days



44% of patients had one or more errors requiring intervention.

Error type	Examples
Medication	• Missing stop dates • Incorrect renal dosing • Duplicative therapy
Durable Medical Equipment (DME)	• Incomplete or absent directions for use
Communication	• Code status discrepancy • Missing referral appointment information • Unclear catheter instructions



3 of 4 communication errors related to medications or durable medical equipment.

LESSONS LEARNED

- Occurrence of communication and medication-related errors is high in hospital to skilled nursing facility (SNF) transitions.
- Regular telehealth videoconference post-discharge rounds with hospital-based and SNF-based care teams provide systematic opportunities for identifying and managing patient-related transitions errors.
- These transitional errors are important targets for system-wide care improvement strategies.

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