Identifying Gaps in Care During Hospital Transitions: A Quality Improvement Initiative in the Transitions of Care Clinic

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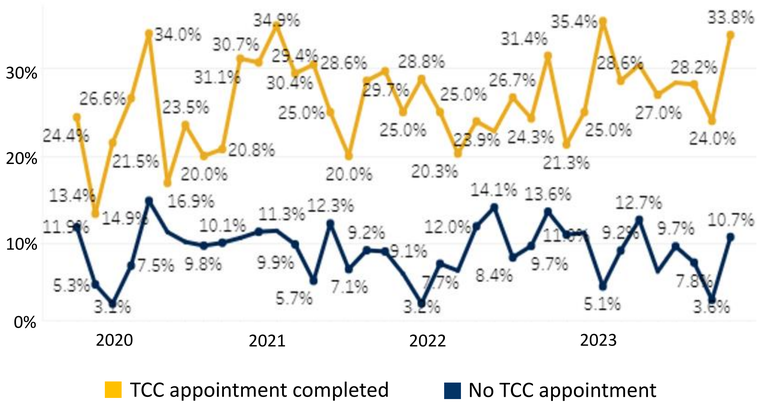
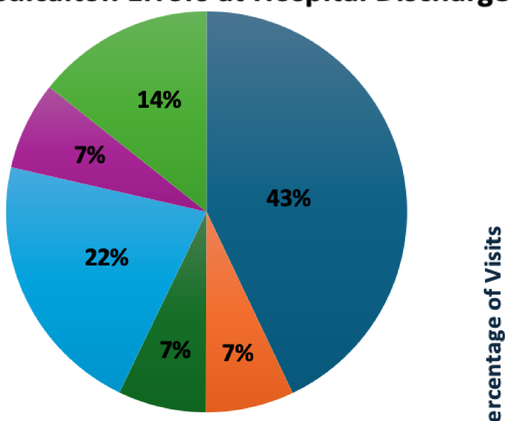
BACKGROUND: The WVU Department of Medicine Transitions of Care Clinic (TCC) was established in 2018 to focus on complex patient discharges, address care gaps, and help prevent readmissions. The clinic is available to all discharged patients seen by WVU internal medicine and for those patients who do not have a primary care doctor. According to the current literature, the average unplanned readmission rate in the US is 15-20%. Nearly 1 in 5 patients (19%) experience an adverse event, with one-third of these events categorized as preventable. The TCC aims to reduce the rate of unplanned readmissions by providing prompt follow-up after discharge via in-person, video conference, and telephone visits. Data collected from TCC has consistently shown significant reductions in 30-day readmissions for patients seen within 14 days of discharge.

TCC impact on 30-Day Readmission Rate



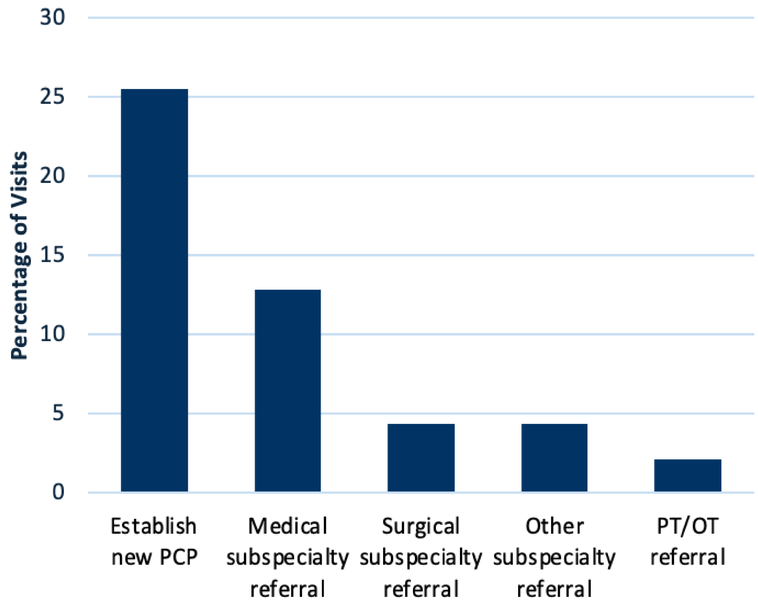
IMPROVEMENT ACTION PLAN: In 2024, TCC clinical staff developed an 18-question post-discharge assessment survey. The survey was created using REDCap and focused on questions regarding the patient's discharge summary, medication list, and transitions of care. Key barriers, such as incomplete medication reconciliation and unscheduled patient follow-ups, were analyzed using the compiled survey responses to identify the most common discharge-related issues.

Medicaiton Errors at Hospital Discharge

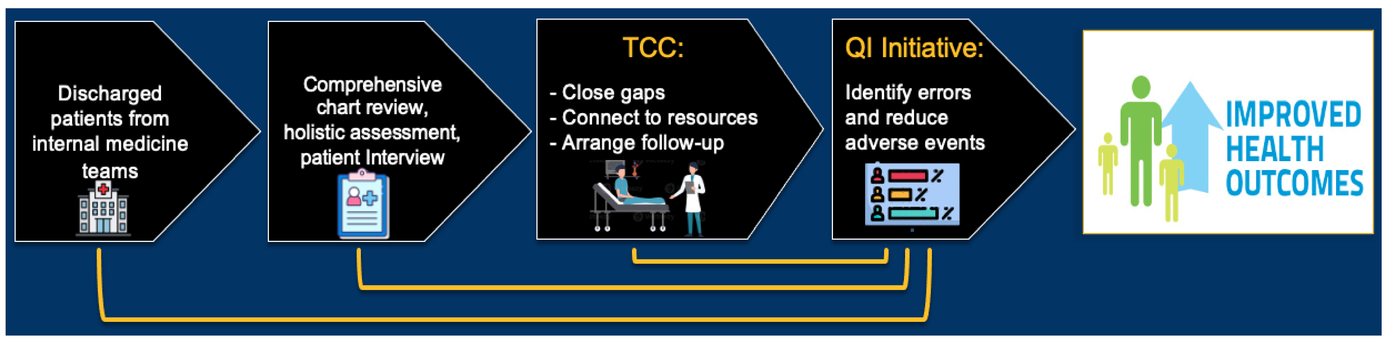


RESULTS: A total of 47 surveys were completed by practitioners in the TCC. Most of the discharged patients were from academic medicine and hospitalist services. In the TCC, 26.7% of evaluated patients had inaccurate medication reconciliation and 14.9% of patients lacked a primary care physician at the time of discharge. During the period between discharge and TCC visit, 38.3% of visits recorded medical care barriers, and 29.8% recorded significant adverse events. The most common interventions at the TCC were establishing new PCP (25.5%) and placing various subspecialty referrals (21.3%).

Interventions at the TCC



SMARTER OBJECTIVE: Our project aims to identify key issues associated with hospital discharge follow-up at J.W. Ruby Memorial Hospital. Using data from a post-discharge survey from July through December 2024, we plan to implement mandatory medication reconciliation training. With an updated version of the survey, we will compare the percentage of discharge-related adverse events in the latter half of 2025 to measure the success of this intervention.



SCALE UP PLAN FOR THE FUTURE: Implement a reminder in the TCC documentation template to ensure a higher completion rate of surveys, increasing power of future studies. Furthermore, surveys can be refined with required responses, measurement and subcategorization of medication errors and interventions, reducing subjective ratings, and incorporating more quantitative assessments.

SUSTAINABILITY PLAN: In the hospital setting, we recommend further medication reconciliation training for residents and review of every discharge medication list by the internal medicine team's pharmacist. Additional protocols could be applied to ensure timely referrals and hospitalization follow-up. Our transitions of care team will conduct future research to identify changes that can be implemented to reduce post-discharge adverse events and readmission rates.

LESSONS LEARNED: Survey tools should be comprehensive, with all critical sections required. Categorizing errors into provider and patient domains allows for a clearer analysis of data. This study identified and raised awareness of adverse and near-miss discharge events within the WVU health system.