

Chapter 4

A Need for Greater Collaboration: Initiatives to Improve Transitions of Care

Mariette Sourial

Palm Beach Atlantic University, USA

Angelica Constanzo

University of Kansas Hospital, USA

Jo Ann M. Bamdas

Florida Atlantic University, USA

Marina E. Ishak

Palm Beach Atlantic University, USA

ABSTRACT

Patient safety concerns have risen to such levels that multiple organizations and initiatives have been created to reduce hospital readmissions and medication errors in the United States healthcare system. Interprofessional education and collaborative practice (IPECP) has become a center of focus in healthcare education and the competency-based programs help health providers function more effectively as a team, train new university and college healthcare students to become ready for collaborative practice, and assist in making new policies and practices to improve today's healthcare system. This chapter provides a comprehensive overview of healthcare initiatives created to help lower hospital readmission rates and polypharmacy errors. These projects, programs, and initiatives optimize patient care while minimizing costs. With pharmacists, physicians, nurses, social workers, and other professionals and caregivers build better teams with improved communication and understanding each other's roles and responsibilities, the global healthcare system will overcome the numerous challenges.

INTRODUCTION

A Patient's Story

TP is a 78-year old African American female who presented to the hospital complaining of shortness of breath. Her shortness of breath in addition to throbbing headaches began a few days ago and worsened today, for which she was admitted. Her past medical history is significant for hypertension, reduced ejection fraction heart failure, non-valvular atrial fibrillation, and hypothyroidism. Patient denies smoking

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or using illicit drug. She reported compliant with her medications and was taking the following, which were written on a piece of a paper: lisinopril 10 mg by mouth daily, carvedilol 6.25 mg by mouth twice daily, furosemide 80 mg by mouth twice daily, diltiazem hydrochloride 120 mg by mouth once daily, rivaroxaban 15 mg by mouth daily, and levothyroxine 75 mcg by mouth every morning. Her pulse upon admission varied from 151 to 92 and her blood pressure between 144/76 mmHg to 160/91 mmHg. Her serum creatinine was 1.9 and her blood urea nitrogen was 35 (her baseline was a serum creatinine of 1.7). Other pertinent labs were within normal limits. ECG showed atrial fibrillation with rapid ventricular response. Upon hospitalization, some of her medication regimens were changed – carvedilol was increased to 12.5 mg by mouth twice daily, lisinopril was decreased to 5 mg by mouth once daily, and furosemide 80 mg by mouth once daily was switched to bumetanide 1 mg by mouth once daily. The discharge instructions were provided by the healthcare team, yet the patient could not recall the discussion. She was confused with regard to the complexity of her medical conditions and the changes in her medication regimen, which were necessary for her post-discharge home care.

Two days later, the patient was readmitted to the hospital with similar symptoms. Upon further discussion, it appears that the patient was confused in her medication regimens and was taking her medications inappropriately. Luckily, she had brought with her the medication bottles, and was referred to the clinical pharmacist for medication reconciliation. The patient was taking carvedilol 12.5 mg by mouth twice daily along with her original regimen of 6.25 mg by mouth twice daily, for a total of 18.75 mg by mouth twice daily. We also discovered that the rivaroxaban 15 mg required prior authorization, but she was going off a physician sample that had a few pills left. Her diltiazem bottle was found to be emptied and dated since last month. When asked, the patient claimed it did not have refills and she had not had been able to visit her cardiologist yet.

Problem

TP's story powerfully reminds the importance of safe and effective transitions of care. She left the healthcare setting without being fully able to care for her conditions due to the lack of appropriate education based on her level of understanding and to gaps in communication between the healthcare providers. In order to be proactive in her own care, TP could have used a notebook to write down important information for discussion with her healthcare providers.

Predominantly, communication gaps are one of the major causes of ineffective transitions of care. Healthcare providers may not communicate information completely between the members of the team, to the patient, or their caregivers. Various risk factors that may contribute to such communication breakdowns include different expectations between senders and receivers, a culture that lacks teamwork and respect, a culture that does not promote a successful hand-off, inadequate time, and lack of standardized procedures (The Joint Commission, Joint Commission Center for Transforming Healthcare, & Joint Commission Resources, n.d.).

Secondly, a patient's level of understanding of the provided education is another major challenge in transitions of care. The patient's understanding can affect the way their health is managed. Sometimes, patients and caregivers receive conflicting information about their health, are excluded from the decision making, and are confused in their medication regimens, as seen in this patient. TP had multiple comorbid conditions and was taking multiple medications with various dosing regimens, placing her at risk for medication errors. Patients and caregivers sometimes are also excluded from the decisions mak-

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