IHI Expedition
Reducing Readmissions by Improving Care Transitions Session 4
Peg Bradke, RN, MA
Thursday, July 25, 2013
These presenters have nothing to disclose

Expedition Coordinator

Kayla DeVincentis, CHES, Project Coordinator, Institute for Healthcare Improvement, currently manages web-based Expeditions and the Executive Quality Leaders Network. She began her career at IHI in the event planning department and has since contributed to the State Action on Avoidable Rehospitalizations (STAAR) Initiative, the Summer Immersion Program, and IHI’s efforts for Medicare-Medicaid enrollees. Kayla leads IHI’s Wellness Initiative and has designed numerous activities, challenges, and educational opportunities to improve the health of her fellow staff members. In addition to implementing the organization’s first employee health risk assessment, Kayla is certified in health education and program planning. Kayla is a graduate of Northeastern University in Boston, MA, where she obtained her Bachelors of Science in Health Science with a concentration in Business Administration.
WebEx Quick Reference

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting...

Please send your message to All Participants
Expedition Director

Saranya Loehrer, MD, MPH. Director, Institute for Healthcare Improvement (IHI), aligns care transitions related programming within IHI and provides coaching and facilitation to teams within the STAAR initiative. She also contributes to IHI’s efforts to adapt promising practices to better care for Medicare-Medicaid beneficiaries and serves as one of IHI’s “content curators” to ensure IHI’s publications and resources are reflective of the most recent innovations and best practices in the field. Saranya received her medical degree from Loyola University Chicago’s Stritch School of Medicine and her Master of Public Health degree from the Harvard School of Public Health, where she served as a Zuckerman Fellow.

Today’s Agenda

- Action Period Report Out
- Passing the Baton: The Handover of Critical Information
- Content In Action
  - Kitsap County Cross Continuum Care Transitions Project (KC4TP)
- Action Period Assignment
Overall Program Aim

The aim of this Expedition is to share strategies for hospitals and their cross-continuum partners to co-design care processes to improve the transition of patients from the hospitals to the next care setting.

Expedition Objectives

At the end of the Expedition each participant will be able to:

- Assess current challenges in reducing avoidable rehospitalizations and identify opportunities for improvement.
- Explain how to build an effective improvement team including patients and families as well as acute, post-acute and community care providers.
- Describe how to use the patient story to build an individualized plan of care.
- Use appreciative inquiry and Teach Back to better understand a patient’s post-acute care needs and capabilities.
- Develop processes with post-acute care providers and community partners to ensure the timely transfer of critical information during patient transitions.
Schedule of Calls

Session 1 – Building the Team You Need to Reduce Readmissions
Date: Thursday, June 6, 12:00-1:30 PM ET

Session 2 – Capturing the Patient Story
Date: Thursday, June 20, 12:00-1:00 PM ET

Session 3 – Assess for Success: Appropriate Post-Acute Follow-up
Date: Thursday, July 11, 12:00-1:00 PM ET

Session 4 – Passing the Baton: The Handover of Critical Information
Date: Thursday, July 25, 12:00-1:00 PM ET

Session 5 – Putting It All Together: Orchestrated Testing and Implementation
Date: Thursday, August 8, 12:00-1:30 PM ET

Faculty

Peg M. Bradke, RN, MA, is Director of Heart Care Services at St. Luke’s Hospital in Cedar Rapids, Iowa. She received her Bachelor’s Degree in Nursing from Mount Mercy College and her Master’s Degree in Nursing Administration from the University of Iowa, College of Nursing. In her 25-year career, she has had various administrative roles in the cardiac care areas. She currently coordinates the Heart and Vascular Service line which includes two intensive care units, two step-down telemetry units, the Cardiac Cath Lab, Electrophysiology Lab, Diagnostic Cardiology, Vascular and Interventional Lab, Respiratory Care, Cardiopulmonary Rehabilitation and Heart Failure and Coumadin Clinics. In addition, Peg is serving as faculty with the Institute for Healthcare Improvement (IHI) on the Transforming Care At the Bedside (TCAB) Initiative and STAAR (STate Action on Avoidable Rehospitalizations Initiative).
Action Period Report Out

- During rounds/huddles, ask "what is the likelihood that this patient will be readmitted in the next 30 days?"

- Observe 1-2 patient transitions for the following:
  - Were follow-up appointments made prior to the patient leaving?
  - Were resources set up based on the post-hospital needs and capabilities of patients and caregivers?
  - Was the key learner/caregiver present for the discharge instructions?
  - Was Teach Back used to assess patient and caregiver understanding of the discharge instructions?

- Make your own histogram for days between admissions.
  - What did you learn from your data? What are your opportunities there?

Action Period Report Out

What did you do?

What surprised you?

What will you do next as a result?
Passing the Baton

The Handover of Critical Information

Peg Bradke, RN, MA

Co-Design of Handover Communications
How Might We….

“….effectively communicate post-acute care plans to patients and community-based providers of care?”

In-depth Review of Residents Who Were Readmitted to the Hospital

- Conduct chart reviews of the last five readmissions, transcribing key information onto the data collection sheets (see Diagnostic Worksheet A or INTERACT Quality Improvement Tool)
- Conduct interviews with residents recently readmitted and their family members (If possible, interview the same individuals whose charts were reviewed)
- Next, conduct interviews with clinicians and staff in the skilled nursing facility to identify problem areas from their perspective. Transcribe information from these interviews onto the data collection sheet (see Diagnostic Worksheet B)
Opportunities Discovered through Diagnostic Reviews

- Lack of a clear picture of the resident’s entire history, including the severity of the resident’s condition and complications during hospitalization (e.g., *C. difficile* infection, pressure ulcers, urinary tract infection, delirium)
- Premature discharge from the hospital with unstable clinical condition
- Inadequate availability and consistency of primary care providers for residents; lack of an available primary care provider who is familiar with the resident’s condition and treatment when a resident’s status changes
- Lack of advance directives, palliative care services, and other types of care that prevent readmission to the hospital
- Lack of understanding of patient and families’ care goals and preferences
Ensure SNF Staff Are Ready and Capable to Care for the Resident

A. Confirm understanding of resident’s care needs from hospital staff
B. Resolve any questions regarding resident transition status to ensure fit between resident needs and SNF resources and capabilities

Learning from STAAR:
- Co-design warm handovers with hospital and SNF.
- Ensure calls are reliably received (do not get “lost”). For example, have a direct phone line for warm handovers or have a receptionist treat all warm handover calls similar to a physician call.
- Have a physician to physician warm handover one day before discharge.
- Consider establishing HHC, SNF or LTC liaisons that are based in the hospital (ex. HHC liaison helps MDs determine qualifications for home health care),
Reconcile Treatment Plan and Medications

A. Re-evaluate the resident’s clinical status since transfer
B. Reconcile the treatment plan and medication list based on an assessment of the resident’s status, information from the hospital, and past knowledge of the resident (if applicable)
C. Make a plan for timely consult when the resident’s condition changes

Learning from STAAR:
- Co-design with the hospital a standardized transfer form to ensure all critical information is reliably shared
- Try out innovative ideas such as sending 3-day supply of meds with the patient
- Include “what matters to the patient” in the warm handover and communicate your understanding of that to the patient

Engage the Resident and Family in a Partnership to Create an Overall Plan of Care

A. Assess the resident’s and family or caregiver’s desires and understanding of the plan of care
B. Reconcile the care plan developed collaboratively with the resident and their family or caregiver

Learning from STAAR:
- Share patient education materials and educational processes across care settings
- Offer education for the staff in HHC, SNF, LTC and community services
- Use the Teach Back method in your conversations with the resident and family.
- Share information about the resident’s health care choices across the continuum
What Are We Learning About Providing Real-time Handover Communications?

- There are a “vital few” critical elements of patient information that should be available at the time of discharge for the community providers
  - “Senders” and “receivers” agree upon the information and design reliable processes to transfer information effectively
- Written handover communication for high-risk patients is insufficient; direct verbal communication allows for inquiry and clarification
- Consider designing standardized handover forms for the community, region, or state

Introducing KC4TP

- Sound for the video will come through you’re the speakers on your computer.
- You can hear the video by turning up your computer volume or plugging in headphones
- We will distribute the YouTube link in case you are unable to hear the audio.
In the beginning...

- March 2012: KC4TP identified information exchange failure when transferring patients from hospital to SNF
- Strategy group formed consisting of SNF and Hospital staff
- Initially researched standardized transfer form
- Draft “Warm Handover Guide” was created using existing SNF report sheet (just do it!)
The process...

• Guide laminated for hospital RN - not a form to complete
• Initially piloted on PCU - December 2012
• Follow up done on each Hospital to SNF discharge to ensure process followed
• Data shared with strategy group
• Pilot expanded to second hospital unit January 2013
• Review of all failures

Next Steps...

• Roll out to entire hospital - August 1, 2013
• Hospital and SNFs will include “WH Guide” as part of new licensed nurse orientation
• Roll out presentations
  – Flyers
  – Newsletters
  – Daily hospital news alerts have been initiated to introduce process
• Evaluation/modification of the “WH Guide” as needed
• Survey monkey to hospital & SNF date TBD
Challenges...

• Time!
• Change in the way things “have always been done”
• Buy-in of hospital staff/understanding the value to SNF
• Consistency in SNF utilization of the WH Guide
• Getting to “reliable” process

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Action Period Assignment

- Design and test a warm handover (phone call) to a post-acute care setting.

Choose 1 of the following:

1. Discuss a recent handover with a post-acute or community partner.
   - Did the community partner get the information they needed in a format they desired? Were there unresolved issues?
   - How could the handover be improved?
   - What could be tested as a result of this assignment going forward?

2. Review the INTERACT Hospital to Post-Acute Care handover tool with one or two of your community partners to determine if this could be utilized as the handover tool.

Chat Time!

Chat in one thing you learned during today’s session.
Expedition Communications

- Listserv for session communications: ReadmissionsExpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes

Final Session

Thursday, August 8, 12:00 PM – 1:30 PM ET
Session 5 – Putting it all Together: Orchestrated Testing and Implementation