Seamless Care: Safe Patient Transitions Between Facilities

January 14, 2016
How to Participate in the Session

- If you have called in by phone, you can “raise your hand” by selecting the hand icon.

- If you would like to call in by phone, select the “phone” icon to receive call in information.

- Select the “Chat Bubble” icon to show the comments box and type your comments and questions in the chat box throughout the session.
Agenda

• Welcome and Collaborative Overview
• EDTC Measures Overview
• Data Submission to NCQC
• Current Results for North Carolina
• Transitions of Care Model
• Improvement Team
• Next Steps
# Collaborative Learning Network – Year 1

## Enroll Hospitals

**Convene ED Improvement Teams**

<table>
<thead>
<tr>
<th>Outpatient Core Measures</th>
<th>Care Transitions</th>
<th>Immunization</th>
<th>HCAHPS &amp; Patient Family Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conduct Assessment</td>
<td>• Conduct Assessment</td>
<td>• Review Hospital Policies and Practices</td>
<td>• Review and interpret HCAHPS Scores</td>
</tr>
<tr>
<td>• Training/Education</td>
<td>• Capture Current ED Transfer Processes Communications</td>
<td>• Conduct Gap Analysis</td>
<td>• Inventory Current PFE Practices</td>
</tr>
<tr>
<td>o QI Basics</td>
<td>• Evaluate Processes for Improvement Opportunities</td>
<td>• Identify Areas for Improvement</td>
<td>• Training/Education</td>
</tr>
<tr>
<td>o Establishing an Improvement Team (including patient/family advisors)</td>
<td>o Prioritize Opportunities</td>
<td>• Training/Education</td>
<td>o Connection Between HCAHPS Scores and PFE</td>
</tr>
<tr>
<td>o Developing an Action Plan</td>
<td>o Develop Action Plans</td>
<td>o Best Practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Include Patient/Family Advisors on Improvement Teams</td>
<td>o Policy and Practice Development (involve patient/family advisors)</td>
<td></td>
</tr>
</tbody>
</table>

- Review and interpret HCAHPS Scores
- Inventory Current PFE Practices
- Training/Education
  - Connection Between HCAHPS Scores and PFE
## Collaborative Learning Network – Year 2

<table>
<thead>
<tr>
<th>Outpatient Core Measures</th>
<th>Care Transitions</th>
<th>Immunization</th>
<th>HCAHPS &amp; Patient Family Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate Processes for Improvement Opportunities</td>
<td>Track Submission and Performance of Measures</td>
<td>Training/Education</td>
<td>Directed toward C-Suite Executives and Accountable Line Staff</td>
</tr>
<tr>
<td>Prioritize &amp; Develop Action Plans</td>
<td>Share Improvements within the Learning Network</td>
<td>o Effective Communication on Immunization Topics</td>
<td>Review Best Practices for Improving HCAHPS Scores</td>
</tr>
<tr>
<td>o Improve OP-1, OP-2, OP-3 and OP-5 Measures</td>
<td>Training/Education</td>
<td>o Introduction to “Learning from Defects” Analysis Tool</td>
<td>o Identify and Implement Two Best Practices</td>
</tr>
<tr>
<td>o Share Performance on Measures</td>
<td>o Intermediate Quality Improvement Strategies</td>
<td>o Understand What Happened When Policy Was Not Followed</td>
<td></td>
</tr>
<tr>
<td>Training/Education</td>
<td></td>
<td>o Identify Improvement Opportunities</td>
<td></td>
</tr>
<tr>
<td>o Best Practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Identifying Areas for Improvement, Developing Action Plans, and Implementing Improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Collaborative Learning Network – Year 3

<table>
<thead>
<tr>
<th>Outpatient Core Measures</th>
<th>Care Transitions</th>
<th>Immunization</th>
<th>HCAHPS &amp; Patient Family Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Monitor Measures</td>
<td>- Sustain Improvements</td>
<td>- Monitor Adherence to Hospital Policies</td>
<td>- Sustain Best Practices Implemented in Yr. 2</td>
</tr>
<tr>
<td>- Spread Involvement from Management of AMI Patients to All Patients</td>
<td>- Complete Second Round of Process Maps for ED Transfer Communication</td>
<td>- Monitor Adherence to Following Best Practices</td>
<td>- Implement an Additional Best Practice</td>
</tr>
<tr>
<td>- Shift Focus to Pain Management and Prevention of Patients Leaving Without Being Seen</td>
<td>- Standardize processes and tools for long-term continuous improvement</td>
<td>- Encourage and Support Analysis of Cases That Do Not Follow Policy</td>
<td>- Plan for Long-Term Sustainability</td>
</tr>
<tr>
<td>- OP-20, OP-21, OP-22</td>
<td>- Analyze for Additional Improvement Opportunities</td>
<td>- Conduct Assessment of Discharge Planning and Medication Reconciliation</td>
<td></td>
</tr>
<tr>
<td>- Share Performance on Measures with Collaborative</td>
<td>- Share Best Practices</td>
<td>- Share Best Practices</td>
<td></td>
</tr>
<tr>
<td>- Continue Emphasis on Inclusion of Patient/Family Advisors on the Improvement Team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Collaborative

- Alleghany Memorial Hospital
- Angel Medical Center
- Cape Fear Valley – Bladen County Hospital
- Cannon Memorial Hospital
- Chatham Hospital
- Dosher Memorial Hospital
- FirstHealth Montgomery Memorial Hospital
- Murphy Medical Center
- Pender Memorial Hospital
- Pioneer Community Hospital of Stokes
- St. Luke’s Hospital
- Swain County Hospital
- Washington County Hospital
Ensuring appropriate and timely care beyond organizational silos is essential to transforming health care.
Transfers from the ED...

• Series of handoffs

• Unfamiliarity with settings and care delivery details of receiving facility

• Inadequate communication to support effective care
Ineffective Transitions...

• Poor outcomes
  o Delays in diagnosis
  o Medication errors
  o Adverse events
  o Inappropriate/unnecessary treatments

• Patient complaints

• Increased length of stay

• Increased costs
Emergency Care in Rural Hospitals

• The size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important.

• Communication between providers promotes continuity of care and may lead to improved patient outcomes.
Did You Know That...

- Communication problems are a major contributing factor to adverse health care events in hospitals, accounting for 65 percent of sentinel events tracked by The Joint Commission.

- An estimated 80 percent of serious medical errors involve miscommunication between caregivers when responsibility for patients is transferred according to TJC Center for Transforming Healthcare.
Why is EDTC Important?

• Assesses how well patient information is communicated from ED to other health care facilities

• Helps EDs provide patients with time-sensitive care that includes transfer to a tertiary care center effectively

• The ability to assess, arrange and transport the patient out the door with the necessary and appropriate information can be of life or death importance
The Seven Elements of EDTC

- Administrative communication
- Patient information
- Vital signs
- Medication information
- Physician information
- Nurse information
- Procedures and tests
Quality Data System (QDS)

Data Entry
North Carolina Aggregate Data
Based on Reporting CAH’s
## Current Benchmarking Data

<table>
<thead>
<tr>
<th>MBQIP Measure</th>
<th>NC Average 4Q14 - 3Q15 (N=2,674)</th>
<th>NC Average Current Quarter (N=749)</th>
<th>National Average Current Quarter (N=33,981)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EDTC-1</strong> Admin. Comm.</td>
<td>98%</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>EDTC-2</strong> Patient Info.</td>
<td>93%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td><strong>EDTC-3</strong> Vital Signs</td>
<td>96%</td>
<td>98%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>EDTC-4</strong> Medic. Info.</td>
<td>94%</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>EDTC-5</strong> Practitioner Info.</td>
<td>96%</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>EDTC-6</strong> Nurse Info.</td>
<td>86%</td>
<td>90%</td>
<td>84%</td>
</tr>
<tr>
<td><strong>EDTC-7</strong> Proc. &amp; Tests</td>
<td>99%</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td><strong>All EDTC</strong></td>
<td>82%</td>
<td>84%</td>
<td>64%</td>
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</table>
## Collaborative Targets

<table>
<thead>
<tr>
<th>MBQIP Measure</th>
<th>Collaborative Baseline 2014</th>
<th>NC Average Current Quarter (N=749)</th>
<th>Collaborative Target 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDTC-1 Admin Communication</td>
<td>99%</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td>EDTC-2 Patient Information</td>
<td>88%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>EDTC-3 Vital Signs</td>
<td>90%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>EDTC-4 Medication Information</td>
<td>89%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>EDTC-5 Practitioner Information</td>
<td>89%</td>
<td>97%</td>
<td>95%</td>
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<tr>
<td>EDTC-6 Nurse Information</td>
<td>82%</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>EDTC-7 Procedures and Tests</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
</tr>
</tbody>
</table>
Discussion Questions

• Data Collection:
  o Challenges with data collection?
  o Particular “pain points”?
  o Tips for ease in data collection?

• Measure Performance:
  o Observations?
  o Is the measure performance reflective of the process performance?
What Does Seamless Care Look Like?
Conceptual Model of Transitions of Care

Source: Improving Transitions of Care: Hospital to Home, National Transitions of Care Coalition, October, 2009, page 25.
Transition of Care Interaction

Sender Accountabilities:
- Complete and timely transfer of key information
- Verification of receipt by intended recipient
- Availability to clarify or answer questions

Receiver Accountabilities:
- Timely acknowledgement of receipt of complete information
- Evaluation of information and determination of plan of care
What are your top three challenges?

• Administrative communication
• Patient information
• Vital signs
• Medication information
• Physician information
• Nurse information
• Procedures and tests
Establishing an ED Transfer Improvement Team

Gaining commitment of hospital leadership:

- Show them the data!
- Share how improvements in ED transfer communication align with other priority health care efforts.
  - Continuity of patient care
  - Error reduction
  - Improved outcomes
  - Increased patient/family satisfaction
Establishing an ED Transfer Improvement Team

Establish an improvement team:

- 5-8 individuals
- Diverse group of individuals
  - Different roles
  - Different perspectives
- Regular meetings
  - Review performance data
  - Identify improvement opportunities
  - Make and monitor improvement plans
Establishing an ED Transfer Improvement Team

Improvement team composition:

• Champion
• Clinical leadership
• Technical expertise
• Day-to-day leadership
• Project sponsorship
Sample Emergency Department Transfer Communications – QI Project Team

Hospital Name:

The project team will work to develop, evaluate and improve the emergency department transfer process. It is important to involve those that work directly with transferring patients from the hospital emergency department to another hospital setting. An appreciation for your hospital and community, include your local physicians, nurses, and staff members.

Sample Agenda - ED Transfer QI Meeting

Date, Time, Location

Participants: Primary Leader/Chairman, Physician Leader, Nurse Manager Leader, Case Manager Leader, Quality Improvement Leader, Patient Services Leader, Local EMS Leader, Community Hospital Staff, Local EMS Leader, Local Emergency Department Staff.

Objectives:
1. ED transfer communications stakeholders are aware of ED challenges and are committed to making improvements.
2. ED communication plan is developed and implemented as noted above.
3. Outcomes are measured, tracked, and reported to all team members.

Introduction:

Project Overview - Project Leader

Determine ED team assembled will meet QI project needs.

ED Transfer Communications - Current State

1. Discuss ED transfer communications measure results
2. Identify challenges and opportunities within the current process.

Action Plan - Development

1. Review current state and identify potential solutions
2. Identify areas where tools or processes can be improved (PDSA cycles)
3. Develop roles and responsibilities
4. Develop timeline

Questions and Next Steps

Identify Next Meeting Date, Location, and Time

Source: Minnesota Medical Association, Site, Transition, Task for Hospital Staff, Transition Team Form, [Website Link]
Next Steps

- Submit Immunization Policies
  - Inpatients
  - Healthcare Personnel
- Submit Data Agreements
- Complete Pre-Site Visit Survey
- Establish and convene your ED Improvement Team
  - Enter team information into QDS
  - Begin mapping the ED transfer communication process
Thank You!

QUESTIONS?