CAH Quality Improvement and Care Transitions Collaborative
Lean Concepts and TeamSTEPPS® Tools Working Together to Improve Quality Outcomes

July 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.
By the end of the presentation, participants will be able to;

1. Identify at least one Team STEPP tool and one LEAN tool that can be utilized with quality process measures

2. Describe how Team STEPPS and LEAN can drive the process to provide improved outcomes when used for quality metrics
The Beginning- FY 2013

- Senior Leadership and Quality Coordinator met - wanted a quality metric that related to Rural Hospitals
- Reviewed AHRQ and found several studies done on communication on transfer from ED to another facility
- Established parameters to be measured based on studies (Vital signs, Allergies, Home Med List reviewed, Time Meds given in ED, Copies of Records sent or faxed within 60 minutes)
- Started with baseline review (88%) and set initial goal of 95%
- Communication
  - ED Staff Meeting – presented what we were measuring, why it was important to ensure information available within 60 minutes
  - ED Medical Staff – Met with ED Medical Director. Explained metric and need to have ‘STAT” dictation completed prior to or within 60 min. of patient transfer
**The Beginning – FY 2013**

### Positives
- EPIC – allergies had to be reviewed or could not proceed in ED assessment navigator
- ED already working on ensuring vitals signs documented within 60 min. of D/C or transfer
- ED Navigator already built to include review of Home meds

### Areas Needing Improvement
- ED physicians dictated notes. Delays in getting dictation completed, especially at night
- No standard work for checking that all documentation was completed and then sent/faxed to receiving hospital

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*SALEM HEALTH
An OHSU Partner*
Results and Actions FY 2013

ED Transfer Communication - FY 2013. - Goal 95%

What is measured:

All transfers:
1. Vital signs documented
2. Allergies reviewed
   GCA-if applicable
3. Home med list reviewed
4. Meds given
5. For all non-SH transfers - information faxed to receiving facility
   (Even OHSU as not everyone has access to our EPIC chart)
Team STEPPS Tool- Checklist- 2013

Tool developed to be used by ED Tech & RN to be sure all elements of transfer completed within 60 minutes of transfer.
Results and Actions FY 2013

1. Ended 2013 with YTD percentage of 67.2%
2. Team met for FY 2014 – ED Transfer Communication became part of Strategy Deployment and would be the hospital wide metric for FY 2014.

ED Transfer Communication - FY 2013. - Goal 95%

What is measured:

All transfers:
1. Vital signs documented
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FY 2014 - Quality Metric.

Using Lean principle, had same outcome measure, but developed hypothesis and process measure

**Outcome Measure**

| ED Transfer Communication to Receiving Hospital within 60 min of transfer | Baseline (2013): 88% | Target: 95% |

**Hypothesis**

“If transfer checklist completed and submitted Then: Would meet ED Transfer Communication within 60 minutes of departure ≥ 95%”

**Process Measure**

Dashboard indicating number of completed transfer checklist
Goal: 100%
Dashboard indicating number of transfers with faxed information
Goal: 100%
### Results with Hypothesis and Outcome Measure - FY 2014

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### Not meeting outcome process for 4 months

- a) Reviewed and updated goal (reduced to 90% based on baseline of 67% in 2013), process measure, and Hypothesis
- b) Watched staff (GEMBA) do transfers
- c) Asked ED staff what they thought would help them meet outcome measurement
- d) Reviewed process of dictation by physicians
- e) At this same time clarification on MBQIP Measures occurred
Physicians follow standard work and complete their dictation/note prior to/immediately upon patient discharge

Hypothesis Statement – Revised 5/21/14

Transfer Communication

IF:

Physicians follow standard work and complete their dictation/note prior to/immediately upon patient discharge

Then: Would meet ED Transfer Communication within 60 minutes of departure > 90%

Nurses complete all documentation, use the transfer checklist, and receive consistent individual feedback on any missed documentation

Hypothesis Statement – Revised 5/21/14

Transfer Communication

IF:

Nurses complete all documentation, use the transfer checklist, and receive consistent individual feedback on any missed documentation

Then: Would meet ED Transfer Communication within 60 minutes of departure > 90%
Action Plan #2 - Clarification of MBQIP Measures to ED Staff- May 2014

Changes to ED Transfer Communication Requirements

S: Requirements for communication on transfer from the ED have changed effective April 1, 2014. The requirement now also includes patients discharged back to any healthcare facility (nursing homes, assisted living etc).

B: The Medicare Beneficiary Quality Improvement Project (MBQIP) - ED Transfer Communication is a quality improvement project selected by the Centers for Medicare & Medicaid Services. The goal of MBQIP is to improve patient care in Critical Access Hospitals. We are required to participate in MBQIP measures.

A: ED Transfer Communication is one of our quality measures and over the last year we have added some of the requirements, (impairment assessment and oral restriction) to meet MBQIP. The final report on all requirements for MBQIP has been issued with the additions/changes we will now implement noted below.

R: Starting April 25, 2014 the following changes/additions will be implemented:

1. CHANGE: Salem Hospital transfers –
   - Do not need to copy or fax any part of the medical record except what you normally send (face sheet, PCS, any paper chart forms, and EMTALA paperwork and STAT Dictation)

2. CONTINUE: All Other Hospital transfers
   - Send/fax information as currently doing – ensure within 60 min of leaving

3. NEW: All Discharges to any Healthcare Facility (Long term Care, Nursing Homes, Assisted Living, Rehabilitation Facilities, Veterans Facilities, Psychiatric Facilities)
   - Send WVH ED Transfer Summary with patient
     - On Discharge/Disposition section choose #15 – transfer another facility
     - On Destination – choose facility patient being discharged to (example: Evergreen, DRV, Avemere etc.)

4. For all transfers/discharges in above, ED RN or Tech must document in patient chart:
   A. Paperwork sent/faxed to receiving hospital/other care facility (examples include EMTALA forms, any paper chart forms and WVH ED Transfer report)
   B. RN must document who SBAR was given to (must document both name and title – ex. Shirley RN)
   C. If no meds given during the ED encounter then a note on discharge must be entered stating, “No meds given”. I have asked that this requirement be reviewed by National Committee (if there are no orders for medications and thus no MAR then why document, No Meds Given?)
     For now please include in your discharge note “No meds given”.
   D. How you sent any labs/imaging studies that were pending when pt transferred, this may be a note added to the patient EHR after they are transferred.
Action Plan # 3—Flow Sheet with ED/Tech Specialty Practice Team

**ED Transfer to Healthcare Facility Process**

**Patient transferring to Salem Hospital**
- PCS, COBRA forms completed.
- Provide copy of COBRA, PCS & Face sheet to Medics
- Check with Physician to make sure Note writer note or Stat Dictation Completed
- Send with Patient the following:
  1. Face Sheet
  2. EMTALA/COBRA Form
  3. Copies of any paper charts (EKG, Trauma, Downtime, Nursing Home med sheet)

**Patient Transferring to Another Hospital/ED (other than Salem)**
- PCS, COBRA forms completed.
- Provide copy of COBRA, PCS & Face sheet to Medics
- Check with Physician to make sure Note writer note or Stat Dictation Completed
- Send with Patient the following:
  1. Face Sheet
  2. EMTALA/COBRA Form
  3. Copies of any paper charts (EKG, Trauma, Downtime, Nursing Home med sheet)
  4. WVH ED Transfer Summary (including Physician Notewriter/Dictation)
  5. DOCUMENT IN EPIC WHAT IS SENT OR FAXED TO RECEIVING HOSPITAL

**Patient Discharged to another Care Facility (Long Term, Assisted, Nursing Home, Psychiatric Unit, VA etc)**
- Check with Physician to make sure Note writer note or Stat Dictation Completed
- Send with Patient 1. WVH ED Transfer Summary (including Physician Notewriter/Dictation)
  2. AVS and other D/C paperwork
  3. DOCUMENT IN EPIC WHAT IS SENT/FAXED TO RECEIVING CARE FACILITY
Action # 4 – More Immediate Feedback to Nurses

- Instead of waiting until end of month – do weekly chart audits

- Manager or Assistant Nurse Manager met with each RN who did not complete all nursing portions of transfer communication
**Action # 5 – Physician Deficiencies**

Provided data analysis to ED Medical Director as to issues with dictation

ED Medical Director met with HIM and IT to use Note-Writer and Dragon Speak to do computer note in EPIC

ED Medical Director worked with EPIC Specialist to develop standardized ED Physician Note

ED Medical Director trained all ED physicians on how to use Note-writer and Dragon Speak by end of 3rd Q FY 2014.
### 2014- Visual Wall – ED Transfer Communication – Outcome Metric

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**Sustained improvement for 6 months and met Outcome Process**

**Decided to keep ED Transfer Communication as Quality Metric for an additional year but increased outcome metric to 92.5%**
Pareto Chart – Area to Focus for Process Metric for FY 2015

MBQIP ED Transfer Metrics FY 2015 - YTD
**Action # 1** Sensory Assessment

- ED RN SPT identified what should be in Epic Navigator
- Then suggested one button to click if no impairments
WEST VALLEY HOSPITAL EMERGENCY DEPARTMENT TRANSFER CHECKLIST

Date of Transfer: ___________________
Receiving Facility: ___________________
Transferring RN: ___________________

Check List:

**Salem Hospital Transfers Packets:** Face Sheet, Yellow Copy Interfacility Transfer Form (Cobra), copies of all paper documentation.

**Packets for Transfers Outside Salem Hospital:** ED Transfer Report Summary, Yellow Copy Interfacility Transfer Form, copies of all paper documentation.

- Admitting/Accepting Physician notified
- Interfacility Transfer Form completed (Cobra) – have charge nurse view document before separating (___) Charge initial
- Face Sheet printed
- EKG Copied
- Copy any X-ray, CT, and/or US preliminary reports not in EPIC (or CD sent)
- ID band on and blackened out (Salem Transfers ONLY)
- Physician Note with H&P and Plan of Care Completed

Nursing Documentation Completed

**FOR NON-SALEM HOSPITAL TRANSFERS:** Fax all documentation to receiving facility within 1 hour of departure

- Time Faxed: ________________
- Any LABS not resulted on ED Transfer Report need to be faxed to receiving facility when resulted
- Time Faxed: ________________

Complete Ambulance Form (PCS)
Contact Dispatch for EMS Transportation

- Time Called: ________________

Document Cobra/Transfer in the notes
ENTER in the Transfer Log

RN Documentation Checklist: (RN check below)

- Vital signs within 60 minutes of patient departure
- Allergies reviewed and updated
- Home medication list up to date and “REVIEWED” is clicked
- “No Medications Given” clicked if applicable
- Patient Impairment Assessment completed
- Functional Cognitive Assessment completed
- NPO documented if applicable
- LDA documented if applicable
- I/O documented (IV fluid Stop time ______________ or Continue at Transfer________)
- SBAR report to receiving facility within 1 hour of patient departure (chart credentials of receiving caregiver in the note)
  - Time Called: ________________

Method of Transportation

- Private Care
- Secure Transport
- Lifeflight/Reach
- Randall Children’s Transport Team or OHSU Panda Team notified of need for transfer: Time: ________________

Mental Health

- Mental Health Screener Notes
- Charge Nurse Signature: ____________________________________________
- Transport Hold
- Police Hold
- Voluntary

Send this form to ED Nurse Manager when complete

NOT A PERMANENT PART OF THE MEDICAL RECORD

Patient Label

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An OHSU Partner
Action Step # 3- Lean and Team STEPPS Tools - Daily Board-
Daily Report and Safety Board

Daily Brief at 0815:

- ED Manager reviews all transfers in last 24 hrs. by 0815 each morning

- Completes data tracking tool with all elements MBQIP ED Transfer Communication

- Number that met all criteria and overall percentage communicated to all

- Same data posted on ED Lean Visual Board in the ED
Lean Tools and Team STEPPS Tools – Outcome Measures

Monthly Quality Coordinator responsible for reviewing Quality, Patient Experience, & Infection Prevention data for all of leadership:

1. R&I data (Regenerate & Improve)  
2. S&O data (Sustain and Operate)
## FY 2106 – Year to Date

### REGENERATE & IMPROVE

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What We Learned on our Journey

1. Observe work done as it is being done (GEMBA). It is valuable when looking at process changes. It clarifies the difference between what the process is on paper and what is really happening.

2. Involve staff who actually do the work when you are looking to improve a process.

3. SBAR communication about change at monthly meetings is not enough – need to have in each shift change for several weeks to ensure all staff learn of changes.

4. Track the elements missed most often in your process (Pareto Chart). It helps focus where need to educate/look at process.

5. Give individual feedback as soon as possible as it increases likelihood that changes to the process will be successful (we went from monthly feedback to daily and have sustained meeting our goal).
Thank You
• **July 15th** – Submission Deadline for **Q2 2016 EDTC Measures** to NC Quality Center via QDS

• **August 1st** – Submission Deadline for **Q1 2016 Outpatient Measures** to QualityNet

• **August 19th** – In-Person Collaborative meeting in Winston-Salem
Thank You!

QUESTIONS?
# NC Quality Center Team

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<th>Title</th>
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<td>Debbie Hunter, MBA</td>
<td>Performance Improvement Specialist/Coach</td>
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<td>Sarah Roberts</td>
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<td>Healthcare Data Analyst</td>
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<td>Sharon McNamara</td>
<td>Coach</td>
<td><a href="mailto:sambossmom@nc.rr.com">sambossmom@nc.rr.com</a></td>
<td></td>
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