Chasing the Perfect Handoff  
The Missing Link to Interoperability  

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**Care Coordination Goals**

The National Quality Strategy aims to **promote effective communication and coordination of care** across the healthcare system by focusing on three goals:

- Improve the quality of care transitions and communications across care settings.
- Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
- Establish shared accountability and integration of communities and healthcare systems to improve quality of care and reduce health disparities.

**Hospital to SNF Communication**

- Major communication problem
  - Easily identified
  - More difficult to solve

  - Eisenhowe Medical Center (EMC) Family Medicine Residency Program highlighted multiple physician concerns regarding the quality, adequacy, and timeliness of EMC-SNF hand-off information.
    - Critical information insufficiently presented
    - Not always timely
    - Both major contributing factors to substandard hand-offs

  - Need for in-depth gap analysis of hospital to post-acute care transitions identified by patient safety review.

**Organization**

- Not-for-profit, academic, community hospital
  - 463 licensed beds with 71 clinics
  - 3,500 employees; 496 affiliated physicians

**2015 Awards & Recognition**

- Most Wired Hospital since 2012
- Magnet Recognition® & NICHE Recognition®
- Leapfrog Hospital Safety Score A
- Ranked in Top 50 US Cardiovascular Hospitals (Truven Health Analytics)
- LGBT Healthcare Equality Leader since 2013 (Healthcare Equality Index)
MU Stage 2 Summary of Care Report

- Too Lengthy
- Inefficient
- Interpretation Literacy Levels
- Incomplete Plan of Care & Progress to Goals
- Negative Impact to Clinical Workflow
- Clinicians Perceived Minimal Benefit to Care
- Technology Challenges
- Clinical Challenges
- Strategic Challenges

EMC-SNF Gap Analysis

- History - Eisenhower Medical Center (EMC) and surrounding SNFs functioned as separate entities

- 2012 Center for Medicare and Medicaid Services (CMS) and Meaningful Use Stage 2 Requirements mandated electronic interoperability and “Summary of Care” (SoCR) report

- February 2014 - EMC formed a SNF Collaborative Committee
  - Aim: to align care providers in the EMC network
  - Goal: to deliver more integrated patient care to the community

- EMC educated SNF staff to the SoCR
  - Process
  - Key elements of the report
  - Establish SNF Internet Protocols Addresses (IPAs)
How Did We Get There

- Conduct Root Cause Analysis
- Identify SNF inbound critical information requirements
- Determine needed hospital outbound documents
- Evaluate clarity of hospital outbound documents
- Direct observations of the Hospital discharge and SNF admission process
- Develop modified eSBAR
- Develop standardization and accountability
- Identify physician champion & desired data elements

Accomplishments

- IPAs
- eSBAR
- SNF Discharge Document Checklist
- Reconciliation of Medication Documents
- Training and Education
- Timeliness of Discharge Summary
- Enhanced SNF Discharge iForm
- Risk Stratification
- ABILITY ILLUMINATE referral process “lights up the care transition process to make faster, easier, more informed connections among patients, acute and post-acute providers.”
  - Similar to Extended Care Information Network (ECIN)

SBAR

SBAR Situation
New EMC-SNF Transfer Communication Process/Outcomes

Created an environment for increased dialogue and positive cooperation between the organizations and among care team members.

More effective communication & more efficient tools resulted in:

- Care providers more confident that information they share assures safe and secure transition of care for every patient.

Results

SNF Survey Identified Continued Improvement Areas, January 2016
Lessons Learned - 1

• Don’t be afraid of change
• Identify a physician champion
• Relationship-based care / patient engagement
• Transition of care pharmacist & Behavioral Health support
• Engage leadership
• Develop relationships
• Schedule routine meetings
• Monitor & measure the process

Lessons Learned - 2

• Develop a SNF dashboard
• SNF designated case manager or color code SNF admissions
• Consider assigning a case manager with responsibility for SNF patients or color code SNF admissions
• To improve the transfers
  – Create a transfer process to include policy and procedure for transfer Accountabilities
  – Determine the information to be sent for referral vs. discharge
  – Put in place the tools, forms, and education for safe transfers
  – Monitor and measure your process
  – Communicate, communicate, and communicate!
Summary

To close the loop for the Hospital and SNF relationship, SNFs will outbound patients to the hospital with a similar practice developed here with INTERACT (Interventions to Reduce Acute Care Transfers)

INTERACT “a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in everyday practice in long-term care facilities.”

Potential Areas for Improvement

- Improve communications during transitions between providers, patients, and caregivers
- Implement SNF electronic medical records that include standardized medication reconciliation and SBAR elements, assess interoperability of “Ability” & “Interact” tools
- Establish points of accountability for sending and receiving care, particularly for hospitalists and SNFists
- Increase the use of case management and professional care coordination
- Expand the role of the pharmacist in transitions of care
- Implement payment systems that align incentives and include performance measures to encourage better transitions of care

Six Communication Best Practices for Transitional Care Management

- Lay The Groundwork Prior To Discharge
- Provide Constant Contact
- Capture Patient Preferences
- Be Persistent
- Automate the Outreach
- Implement Smart Reminder Messaging
Four High Impact Areas

- Linkages and Synchronization
- Individuals’ Progression Toward Goals
- Comprehensive Assessment
- Shared Accountability

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References


That’s Enough

Thanks for listening!