Minnesota Hospital Association (MHA)
Safe Transitions of Care Pilot
May 25, 2011

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Minnesota Hospital Association

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St. Cloud Hospital
At the conclusion of this learning activity, participants will be able to:

1. Identify key changes and strategies that were used to reduce avoidable readmissions.
2. Describe how the program was developed and tools the team used.
3. Discuss the outcomes of the program.
4. Discuss how these best practices may be applied in their own organization.
Tania Daniels and Kay Greenlee have no relevant financial relationships to disclose and do not intend to discuss off-label or investigational uses of commercial products or devices.
About Minnesota Hospital Association

- Represents 145 member hospitals; 17 health systems:
  - 593,000 inpatient visits
  - 9.8 million outpatient visits
  - 107,000 employees
  - $4.47 billion economic impact with goods and services
MHA’s Mission, Vision, Values

MISSION
To enhance the ability of the members to achieve their missions and goals

VISION
To be the state’s most influential, trusted and respected leader in health care policy and advocacy, and a valued resource for information and knowledge.

VALUES
- Commitment to affordable access to quality health care for all Minnesotans.
- Trust and integrity.
- Leadership through knowledge-based solutions.
- Collaborative solutions.
- Organizational accountability.
- Community of interests.
Patient Safety/Quality is a top MHA Priority

- Health Care Reform
- Education and Trustee Services
- Patient Safety and Quality
- Advocacy and Representation
- Community Benefits
- Data and Information Services
- Member Relations and Communications
- Work Force
MHA Safe Transitions of Care Workgroup

- Potential safety issue raised: communication issues that lead to unsafe transitions with hospital-to-hospital (and other) transfers
- MHA Patient Safety Committee commissioned safe transition workgroup: Chaired by Karen MacDonald, HealthEast
  - Identified safety gaps and core elements of information to address these gaps
  - Launched pilot project to test core elements, gap analysis, and toolkit
MHA Safe Transition of Care Workgroup

- Karen MacDonald, Health East (Chair)
- Cindy Cross, Granite Falls Hospital
- Dr. Ken Kephart, Fairview
- Marilyn Graftstrom, LifeCare Medical Center
- Kay Greenlee, St. Cloud Hospital
- Barb Stricker, Health East Bethesda Hospital
- Pennie Viggiano, Health East
- Sherril Zehr, Fairview
- Tania Daniels and Julie Apold, MHA
MHA “Safe Transitions of Care” Pilot

Background
Patient safety is a top priority for Minnesota hospitals and health care professionals. However, communication failures between settings during transitions of care can compromise patient safety and quality of care. A recent study of Medicare patients after hospital discharge found that nearly one-quarter “experienced complicated care transitions.” And an estimated 60 percent of medication errors occur during times of transition: upon admission, transfer, or discharge of a patient.

In efforts to address this safety issue, the MHA Patient Safety Committee commissioned a task force to identify patient safety gaps due to transitions of care and core elements to address these gaps. Appreciating a significant amount activity to prevent readmissions both within organizations and throughout the Minnesota community, this project is intended to be one component to further address hospital readmissions.

Overall Goal
Improve patient safety by standardizing transitions of care between hospitals and across settings.

Potential Outcome Goals

Facility Specific:
- Fewer preventable 30 day readmissions
- Increased patient satisfaction (HCAHPS)
- Fewer preventable 7 day ER visits
- Fewer follow-up phone calls
- Fewer medication errors

Statewide Initiative:
- Toolkit of resources developed and disseminated
- Toolkit accessed and used to develop transfer forms and processes
- # of facilities using core elements/best practices (survey)

Pilot Goal
- Evaluate appropriateness of and provide feedback for edits to safe transition elements
- Utilize tools in toolkit (e.g. crosswalk, gap analysis) and recommend edits /additions
- Evaluate metrics (facility specific, statewide, gap analysis assessment questions)
- Identify mentor organizations

Timeline
- Sept 2010 – Initial meeting of pilot sites/teams to discuss pilot project
- Oct - Nov 2010 – Pilot sites measure baseline and develop pilot forms/process
- Dec-March 2011 – Pilot period
- April 2011 – Pilot sites re-measure and participate in evaluation of pilot
Purpose:
- Improve patient safety by standardizing transitions of care between hospitals and across settings.

Timeline:
- Sept 2010: Webinar Kick-off
- Oct-Nov, 2010: Gap Analysis baseline completed
- Dec-March, 2010: Core element cross walk, tested core elements of information, gap analysis roadmap, and other tools
- April 2011: Final Gap Analysis, final meeting to evaluate/modify core elements, gap analysis, and toolkit based on pilot findings
MHA Safe Transition Pilot Sites (13)

- Essentia Fosston
- Fairview UMC - Mesabi, Hibbing
- Granite Falls Municipal Hosp
- Essentia St. Joseph’s, Brainerd
- CentraCare St. Cloud Hospital
- Mercy Hosp. Moose Lake
- Rice Memorial, Willmar
- Fairview Northland, Princeton
- Sanford Jackson
- Olmsted Med. Center, Rochester
- HealthEast St. Joseph’s, St. Paul; St. John’s Maplewood
- Fairview Red Wing
13 sites from across the state
- Large rural hospitals
- Small rural hospitals
- Large urban hospitals

Across variety of settings, hospital to/from:
- SNF
- Assisted living
- LTC
- Community behavioral health
- Home health
- Adult Foster Care
- Hospice
- DME Agencies
Action Steps for Pilot Facility

• Senior leadership sign-off to participate in pilot project.
• Specify pilot population.
• Measure baseline:
  o Audit of crosswalk elements completed; gap analysis assessment questions
• Convene improvement team to develop pilot process.
• Incorporate the MHA safe transition elements into transition documentation. Elements should be on the first page of documentation.
Action Steps for Pilot Facility (Cont.)

• Conduct 4 month pilot to evaluate safe transition elements and 2-3 tools from toolkit.
• Use elements on a minimum of 30-100 patient transitions.
• Participate in process to revise safe transition core elements, gap analysis, and tools.
• Share new tools to be added to toolkit.
• Serve as mentor facility for full roll-out.
• Re-measure baseline data.
Project team members will vary by institution. The project team will work to develop, evaluate, and improve the transitions process. It is important to involve those that work directly with transitioning patients from one facility/setting to another facility/setting. As appropriate for your institution, include operational and physician champions, unit leaders, case managers, social workers, and other direct care providers who routinely work in the area. Consider incorporating this work into an already established team/work group that is addressing readmissions or other quality/safety improvement initiatives.

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<th>Name (Include Credentials)</th>
<th>Title/Position</th>
<th>Role</th>
<th>Contact Number/Email</th>
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<td>Project Team Leader/Operational Champion</td>
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MHA Implementation Support

• “SAFE Transitions of Care” form/core elements for use during all patient transitions of care
• Forum for sharing successes and challenges: monthly conference calls, in-person meetings, list serve
• Infrastructure: 39 question Gap Analysis
• Developed Web based Toolkit
  o On-line gap analysis
  o Core element crosswalk
  o Transition form
  o Model Policy
  o Education Tools
  o Pilot measurement
Example areas that need ‘safe’ communication

Lack of communicating:
- Falls or pressure ulcer risk
- Isolation precautions
- Critical care tests/results
- Continuation of care plan e.g., timing of care, meds, rehab, drains/tubes
- Who is responsible for patient
- Patient’s readiness for transition
Example MHA Core Elements of Information to assure ‘Safe’ communication

- Do the following core elements of information exist?
- Are they in the 1st page of transfer documentation?
  - Falls risk
  - Pressure ulcers/skin integrity
  - Infection/isolation precautions
  - Lab/test results and values from previous 24 hours and other results and values as appropriate to the patient’s condition, including any pending results (e.g. blood glucose; INR, radiology, others)
  - Medication reconciliation list (includes diagnosis associated with medication and any sliding scales)
Gap Analysis Infrastructure “SAFE”

- **S** = Safe transition teams
  - Interdisciplinary team (physician, senior executive, Operational champion)
  - Engage key stakeholders

- **A** = Access to information
  - Verify the completion of SAFE TRANSITIONS
  - Evaluate for learning opportunity

- **F** = Facility expectations (hard stop)

- **E** = Educate staff and patients
Gap Analysis Principles

Based on “Transitions of Care Consensus Policy Statement,” American College of Physicians-et al.

- **Accountability**
  - All transitions must include records that contain core elements

- **Responsibility**
  - At every point during care transition, patients and their families must know who is responsible for care and how to contact the caregiver

- **Coordination of Care**
Gap Analysis Principles (Continued)

- Patient/Family Involvement
- Communication
  - Clinicians or institutions must provide a clear and direct communication infrastructure, including transition records, treatment plans, and follow-up expectations
- Timeliness
- Standards and metrics
Safe Transitions Gap Analysis

Safe transitions are dependent upon structures and processes which have been identified as the Safe Components and Actions. Implementation of the safe transitions program should start with a gap analysis to examine how your organization is currently performing. The gap analysis provides insight into the needs for improvement toward safe transitions of care.

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<th>Safe Component</th>
<th>Specific Action</th>
<th>Assessment Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Safe transition teams</td>
<td>● Provide support and expectations for SAFE transitions of care&lt;br&gt;● Adopt an interdisciplinary SAFE TRANSITION coordinator&lt;br&gt;● Engage key stakeholders</td>
<td>● Senior Leadership has identified a physician</td>
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<th>Principle/Standard</th>
<th>Specific Action</th>
<th>Assessment Questions</th>
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<td>Accountability</td>
<td>● Create communication tool (form, report, electronic tool) that contains core and additional elements for each type of transition&lt;br&gt;● Complete Transitions of Care Transfer Form&lt;br&gt;● Hold team members accountable when the SAFE TRANSITION is not completed regardless of whether or not an adverse event occurs</td>
<td>● The facility requires AND has a designated form that contains core elements for each appropriate transition setting&lt;br&gt;○ Hospital to SNF, LTAC, Hospice, Post Care, Group Home, Assisted Living&lt;br&gt;○ SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living to Hospital&lt;br&gt;○ Emergency Department to Hospital, LTAC, Hospice, Home Care, Group Home, Assisted Living&lt;br&gt;○ The facility requires AND has a designated form that contains additional elements for each appropriate transition setting&lt;br&gt;○ Hospital to SNF, LTAC, Hospice, Post Care, Group Home, Assisted Living&lt;br&gt;○ SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living to Hospital&lt;br&gt;○ Emergency Department to Hospital, LTAC, Hospice, Home Care, Group Home, Assisted Living</td>
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Pilot Findings: Gaps addressed

Safe Transition Gap Analysis: Overall 55% implementation of infrastructure best practices at baseline (increased to 71% during 4 month pilot)

- Senior Leadership has identified a physician champion(s) and/or senior executive for SAFE TRANSITIONS (64% to 92%)

- Senior Leadership has defined roles, set expectations and provides support for the champion(s) (50 % to 83%)
Pilot Findings: Gaps addressed (Cont.)

- Individual roles in SAFE TRANSITIONS are clearly defined (36% to 75%)
- Stakeholder representation on team includes all transition settings (29% to 92%)
- The facility has a process in place to audit the completion of SAFE TRANSITIONS through audits (25% to 75%)
- The facility requires AND has a designated mechanism of communication to provide caregiver contact information to patients and their family (58% to 82%)
Pilot Findings: Ongoing Gaps

- Data is shared with the facility’s medical staff on a regular basis (42%)
- Expectations and supporting education have been incorporated into orientation for new physicians and other practitioners involved in transitions (45%)
- Patient/family safe transition education tools are disseminated as appropriate (36%)
Pilot Findings: Ongoing Gaps (Cont.)

- The facility requires AND has a designated form that contains core elements for each appropriate transition from Emergency Department to all settings. (36%)
- The facility requires AND has a designated form that contains additional elements for each appropriate transition from all settings to hospital. (45%)
MHA Safe Transitions
Pilot Feedback Tool

Pilot Feedback Goals:
- Understand transferring facility key contact’s experience with use of core elements
- Understand receiving facility key contact’s experience with use of core elements
- Learn about transferring facility staff’s perception of transitions before and after use of core elements
- Learn about receiving facility staff’s perception of transitions before and after use of core elements
- Gather feedback about patient’s perception of transition/use of core elements

Pilot Facility Considerations:
- Identify who from transferring facility will call receiving facility (e.g. social worker, case manager) to gather feedback below
- Establish contact at receiving facility that will provide the below feedback
- Call receiving facility one day after patient transferred to gather feedback
- Collect feedback on greater than 30 patients (ideally 31-100 patients)
- Spread gathering of feedback over course of four month pilot period
Pilot Measurement

Short Term Measurement:

- Safe Transition Gap Analysis: Increased from 55% to 71%
- Transferring Facility Survey: Increased satisfaction
- Receiving Facility Survey: Increased satisfaction
- Perceived high level of patient/family satisfaction
- Pilot site transition of care teams: value of networking and developing new community relationships
- Decreased follow-up calls for clarification
Long Term Impact of Safe Transitions

- Studies have shown poor communication during transitions leads to increased rates in hospital readmissions, medical errors (Epstein, AM, “Revisiting Readmissions-Changing Incentives for Shared Accountability,” New England Journal of Medicine, 2009:360(14)1457-1459)

- Short term goal of improving transition communication will impact patient safety in long term
  - Medication events/missed doses
  - Delayed care/redundant tests
  - Readmissions

- Pilot sites beginning to measure: ER visits, overall readmissions or specific diagnosis readmissions
  - Outcome measures will take more than 4 months to measure
Pilot Successes/Learning

- Safe transition operational champion is key
- Process of nurse to nurse call/handoff one of most successful pilot strategies
- Significant value with engaging community/stakeholders across settings
- Safe transition gap analysis is infrastructure for smooth, safe transitions- which is one component of reducing readmissions
- Increased satisfaction of patient/family, transferring and receiving facility staff
- Reduced follow-up calls required with use of MHA core elements of information
Pilot Challenges/Learning

- Beneficial for pilot sites to align safe transition of care work with existing infrastructures (d/c committee) and/or process improvement work (e.g. readmission)
- Amount of work in 4 month timeframe
- Many communication gaps closed, but more work to do
- Medication orders/medication reconciliation
- Defining metrics/audits
- Incorporating with EHR
- Instituting hard stop policy
- Provider and patient education
- Patients transferring to/from emergency department
St. Cloud Hospital’s Experience with pilot and implementing core elements

• Kay Greenlee, RN
  Director, Clinical Utilization/ Quality Resource
  St. Cloud Hospital
Next Steps

- Roll-out to all Minnesota hospitals
- Align with ICSI and Stratis Health Readmissions work
Next Webinar

6/8  ICSI/MHA RARE Networking Webinar by Eric Coleman, Univ of CO. The Care Transitions Program

To suggest future topics for this series of ICSI/MHA Reducing Avoidable Readmissions Effectively “RARE” Networking Webinars:
Contact: Kathy.Cummings@icsi.org
Minnesota RARE Campaign

Watch for

Upcoming Information

Minnesota Campaign to Reduce Avoidable Readmissions