Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Creating Regional Partnerships to Improve Care Transitions

June 2014 *Part 3 of 4*

Care Transitions Programs: Improving Handoffs

When an elderly patient or a patient with a serious or complex illness is discharged from the hospital, that person is particularly vulnerable. As patients move from one care setting to another, problems such as lack of follow-up care and miscommunication among clinicians often occur and can put patients at risk for serious complications and hospital readmission. Some patients have additional problems such as depression, social isolation, or a lack of housing or transportation that may increase their risk of hospital readmission. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, at a cost of more than $26 billion every year.[i]

Effective handoffs help to reduce medical errors that may result from miscommunication. Many physicians, nurses, and other providers are involved in a patient's care, so effective communication is critical. *Aligning Forces for Quality* (AF4Q) alliances have identified that it is critical to implement methods that make it easier to communicate up-to-date information on the patient's condition and treatment when patients move from one care setting to another.

About *Aligning Forces for Quality*

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

Health care organizations often struggle with how to ensure that critical information about a patient is communicated between clinicians when a patient moves from one setting to another. Several AF4Q Alliances have implemented or are partnering in care transitions programs using care transition coaches to ensure that patient care is coordinated across care settings. In this brief, we highlighted successful approaches alliances have implemented to support better communication during patient handoffs for patients in a 30-day care transitions program.

Here's how care transitions teams in two alliances are sharing information and improving communication during handoffs.*

Case Study: The Care Transitions Program at St. Joseph Health System

Since the summer of 2012, the Care Transitions coaching team at St. Joseph Health System in Humboldt County, CA,** has been working to improve handoffs by serving as a liaison between the hospital staff and local safety-net primary care practices. Each member of the coaching team is assigned a group of local primary care clinics. The coaches contact the clinics by phone or fax to let them know when one of their patients has been admitted or discharged from the hospital and invite them to provide information on the patient.

The staff at the clinics can often assist with issues like medication reconciliation and provide important information about a patient's clinical or psychosocial history that might not be evident when they're admitted to the hospital—for instance, they might point out that a patient is in a treatment program for prescription pain medication dependence. One of the primary care clinic systems has also developed a business agreement that provides the Care Transitions team with read-only access to their electronic medical record system so they can share patients' medical records with the hospital staff. "We've found that we can communicate the challenging information that needs to be better addressed and help the clinicians look at the individual patient in a more holistic way," said Sharon Hunter, RN, PHN, Care Transitions Program manager at St. Joseph Health System.

Case Study: AF4Q-South Central Pennsylvania

AF4Q–South Central Pennsylvania's (SCPA) Nurses Council held a meeting in 2011 to bring together nurse leaders from local hospitals and skilled nursing facilities and a physician who is the chair of the Provider Advisory Council to talk about reducing unnecessary hospital readmissions and improving communication between clinicians. They realized misunderstandings often occurred when a nurse at a skilled nursing facility called a physician at the hospital about a change in a patient's condition. The physician would sometimes jump to the conclusion that the patient needed to go the ED, for example, rather than exploring what the nurse could do to offer treatments or tests at the skilled nursing facility instead.

Why Are Handoffs Important?

Effective handoffs help reduce medical errors that may result from miscommunication. Many physicians, nurses, and other providers are involved in a patient's care, all needing up-to-date information on the patient's condition and treatment when they move from one care setting to another.

Use a Standardized Communication Tool

SBAR is a structured model for communicating patient information between health care workers.

Teach back is a method in which the recipient of information repeats it back to the health care worker—in his or her own words—to make sure the recipient understands what was said.

S—Situation
B—Background
A—Assessment
R—Recommendation
T—Teach Back

To enhance communication during handoffs, the council decided to initiate a pilot in which hospitals and skilled nursing facilities adopted a modified version of a communication technique called SBAR (which stands for Situation-Background-Assessment-Recommendation). SBAR, originally adapted for this purpose by Wellspan, standardizes the information that should be communicated about a patient's condition during any interaction between clinicians. The council decided to use a modified version of the technique (known as SBART) that includes a "teach back" component in which the recipients of information are expected to repeat the information they just learned in their own words to demonstrate they understood it.

The pilot began in the spring of 2012 and includes four hospitals in York and Adams counties, each of which has at least one nursing home partner. AF4Q-SCPA provided educational sessions and materials, but it was up to each facility to figure out how it wanted to implement the SBART method. As part of the pilot, some of the hospitals are using a new standardized written discharge instructions form that is easier to read and includes only the most relevant information the receiving nurse at the skilled nursing facility would need. At one hospital, the primary nurse contact always makes a follow-up call to the receiving nurse at the skilled nursing facility after a patient is transferred just to check in and see if there are any questions.

Samantha Obeck, quality improvement coordinator for AF4Q-SCPA, says the use of the SBART technique already has led to better communication and more collaboration between clinicians. She recalled an incident when a nurse at a skilled nursing facility that is part of the pilot contacted a physician at a hospital about a patient whose condition was deteriorating and used SBART to discuss the case with him. Initially, the physician recommended that she send the patient to the ED. But she pointed out her facility could provide a urinalysis and give the patient IV antibiotic therapy if necessary. Working together, they were able to prevent an unnecessary ED visit. "SBART is a tool that empowers nurses to have these kinds of conversations with physicians and to make recommendations," said Obeck. The hospitals in the

pilot now have incorporated SBART into handoff communication within their own facilities as well. They've adopted it, for instance, as part of the process of bedside reporting and of transitioning a patient from one floor or department to another.

**This "peer-to-peer" meeting about care transitions was held on May 7, 2013, in Chicago.* Aligning Forces for Quality *organized and funded the meeting, with a goal of sharing strategies, tools, and process designs to increase footprint, increase enrollment, decrease refusals, and report data. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program (CCTP) unless otherwise indicated. Attendees included Sheri Vogel (moderator), Nancy Strassel, and Rhonda Prince from the Greater Cincinnati Health Council; Kim Clark and Ken Wilson from the Council on Aging of Southwestern Ohio; Shelley Hirshberg, Megan Havey, Mistine Keis, and Kate Ebersole from the P2 Collaborative of Western New York; Cathy Davis, Poornima Kumar, Rosemary Graves, Trent DeVreugd, and Mark Gunther from the Kansas City Quality Improvement Consortium; and Lori O'Connor from Elder Services of the Merrimack Valley.*

***The Humboldt County, CA, Alliance was not involved in CCTP.*

Successful Practices To Improve Handoffs

- Assign care transition coaches to groups of primary care practices
- Use phone or fax to let primary care physicians know when one of their patients has been admitted to or discharged from the hospital.
- Provide read-only access to patients' medical records.
- Collaborate with patients' primary care providers to obtain any health care information the hospital staff needs.
- Collaborate with hospital care providers to provide any health care information the primary care physician needs.
- Use structured communication methods.

References

[i] *The Revolving Door: A Report on U.S. Hospital Readmissions*. Princeton, NJ: The Robert Wood Johnson Foundation, 2013.

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.