



**SINI 2016**  
26th Summer Institute in Nursing Informatics  
Informatics at the Crossroads of Care Coordination  
July 20-22, 2016  
University of Maryland School of Nursing, Baltimore, Maryland

**Chasing the Perfect Handoff  
The Missing Link to Interoperability**

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## 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*)

## 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.

National Quality Forum, 2012

## Hospital to SNF Communication

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


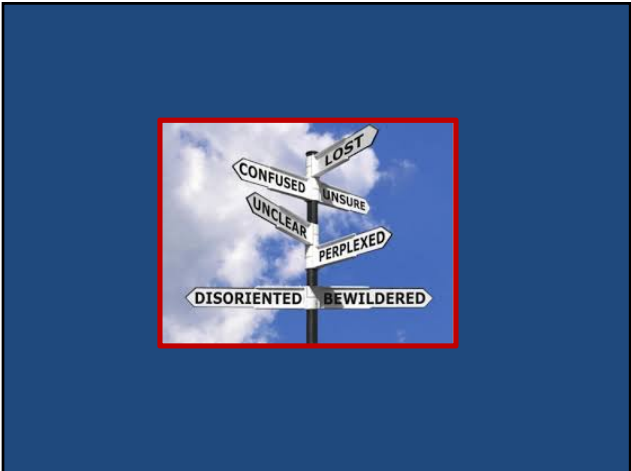


### MU Stage 2 Summary of Care Report

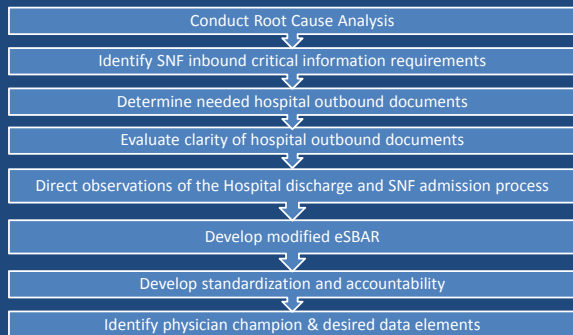
- Too Lengthy
- Inefficient
- Interpretation Literacy Levels
- Incomplete Plan of Care & Progress to Goals
- Negative Impact to Clinical Workflow
- Clinicians Perceived Minimal Benefit to Care
- Technology Challenges
- Clinical Challenges
- Strategic Challenges

### 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



## 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)

Ability Network.com - 2016

## SBAR

## SBAR Situation

\*\*\*Latest Summarized Patient Data Only (as of 07/15/2016 15:00), Complete Data Only\*\*\* 11548091

<b>S</b> <b>DOB:</b> 12/29/1939 <b>Age:</b> 76 Y <b>AdmLd:</b> 6/20/2016 <b>ET:</b> IP <b>Diagnosis:</b> (W)-Left Leg Cellulitis <b>Surgery:</b> <b>Anesthesia Type:</b> general (06/22 12:44) <b>Contact Info:</b> NHS: Name: Ryan Cussen; Cell: 707-235-2236; Res: son.ryan@... Pre/Post OP: Person: son.ryan	<b>Allergies:</b> (Only first 10 allergies listed) (NC)=Needs Confirmation <b>Height/BMI/Wt:</b> (Latest since admit) Hgt: 68in converted (06/26-14:14); BMI: 24 (06/23-11:23) Cty Wt: 73.8kg daily measured (06/26-14:10) Adm Wt: 71.47kg adm/measured (06/23-11:23) <b>Code Status:</b> full code (06/20 23:52) <b>Advance Directive:</b> Ad Dir: DNR Requested (06/13/15) (77-44)	<b>Attending Physician:</b> Carl, Terry L, MD (SME; No Active Orders Team Color: No Active Orders) <b>Consulting Physician:</b> (Only listed if listed) Charly, Brian M, Pharmacy; Christopher M, Keating, Matthew J, DeLuca, Measoud G, DeLuca, Measoud Schultz, Karl; Varsallo, Matthew OpOut: N
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## SBAR Background

<b>B</b>	<b>Medical History:</b> (Latest Rapid RespCode)	<b>MRSA Screen/Cultures:</b>
	Cataract (bilateral eyes), Osteoarthritis, Hepatitis, Hernia (right inguinal hernia at age 4, not sure which hepatitis, possibly Hep C), Skin cancer (mole removed from left shoulder early stage cancer), Other (sees dermatologist early cancer mole), cholecystitis, measles, mumps	Culture: No MRSA (06/21-07/01)
<b>Surgical History:</b>	<b>Vaccinations:</b> (Vaccine hx and admin)	<b>Activity:</b> Ambulate As Tolerated Confin (06/22-06/26)
<b>Risk/Safety:</b>		
Fall Risk Score: 2 (07/15 11:09)	ASA Score: 2	
Oral Risk Score: 23 (07/15 11:09)	Katz Per Hosp: 4 (06/23 17:00) Katz Adm/DC: 6 (06/23 17:00)	

## SBAR Assessment

<b>A</b>	<b>Neurocognition:</b> (Last 24hrs for Basic Access and GCS Total)	<b>Pain:</b> (Scale last 24hrs, Active Pump/10 mm)
	Basic Access: HCL (07/13 11:09)	Oral pain (07/13 11:09)
<b>C</b>	<b>Cardiac Function:</b> (Last 24hrs, Active (ASP, AL, PM, PA sites))	<b>Vital Signs:</b> (Last 24hrs)
	Basic Access: HCL (07/13 11:09)	T: 36.2 2P oral (07/13 14:30)
<b>V</b>	<b>VTE Prophyl:</b> Mech: (131) Sequential compression device (NSG) (06/24-07/05), Pharm: (25) Heparin IV (06/22-07/04)	<b>VS Order:</b> Vital Signs, Confin Routine (06/27-09/40)
<b>R</b>	<b>Respiratory Functions:</b> (Last 24hrs, Active Chest Tube sites)	<b>Lab/Specs:</b> (Last 24hrs)
	Basic Access: HCL (07/13 11:09)	Tran 3P oral (07/13 14:30)
<b>E</b>	<b>Elimination Gt:</b> (Last 24hrs, Active Gt, Ost sites)	<b>Supplements:</b> Nutrition Comments (07/09 13:27)
	Basic Access: HCL (07/13 11:09)	Lab/Specs: (Last 24hrs)
<b>I</b>	<b>GI Prophyl:</b>	<b>Intake and Output:</b>
	Basic Access: HCL (07/13 11:09)	07/13 07:24-07/13 19:39
		In: 1360, Out: 3, Net: 1366
		07/14 00:00-07/14 07:00
		In: 375, Out: 5, Net: 370
		<b>One:</b> No Active I&O Order

## SBAR Recommendations

<b>R</b>	<b>Ser Labs:</b> (Last 24hrs)	<b>Blood Glucose:</b> (Linet 4)	<b>Ordr:</b> No Active I&O Order	<b>Select Orders:</b> (ST, OT, PT, EEG, EKG and Echo, MR, Neum, CT orders)
	Sodium 138 (07/15 04:43)			Physical Therapy (06/25 07:43), ECG/ECG/ECG (06/21 06:19)
<b>o</b>	Potassium 3.5 (07/15 04:43)			
<b>c</b>	BUN 11 (07/15 04:43)			
<b>e</b>	Creatinine 0.6 (07/15 04:43)			
<b>m</b>	White Blood Cell 13.1 (07/15 04:43)			
<b>n</b>	Hemoglobin 7.3 (07/15 04:43)			
<b>d</b>	HCT 24.4 (07/15 04:43)			
<b>a</b>	Platelet Count 40 (07/15 04:43)			
<b>i</b>	Magnesium 2.2 (07/15 04:43)			
<b>o</b>	Phosphorus 2.1 (07/15 04:43)			
<b>n</b>				
<b>t</b>				
<b>i</b>	<b>Cultures:</b> (Last 8 results)			
<b>o</b>	(06/27-07/25) Final-Blood Aerobic Only			
<b>n</b>	(06/27-07/15) Final-Blood Aerobic Only			
<b>d</b>	(06/20-22/20) Final-Blood Aerobic Only			
<b>a</b>	(06/20-22/20) Final-Blood Aerobic Only			
<b>i</b>				

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CASE MANAGEMENT/NURSING TRANSFER CHECKLIST	
PATIENT NAME _____	ACCOUNT NUMBER _____
SNF _____ Phone Number _____	TRANSPORTED BY _____ PU TIME _____
PHONE NUMBER _____	
Chart Copy Information:	
NOTICE: When you print a later version of any report, remove the previous report and all older copies.	
RN - Latest possible on day of discharge:	
<input type="checkbox"/> Discharge Medication List <input type="checkbox"/> SBAR <input type="checkbox"/> MAs (Medication Administration Report) <input type="checkbox"/> Wound care (notes, instructions, and physician orders) <input type="checkbox"/> Report Called to SNF - Name: _____ Date/Time: _____	
Case Management:	
<input type="checkbox"/> Face Sheet <input type="checkbox"/> IEP <input type="checkbox"/> Consulting Progress Reports <input type="checkbox"/> PFIOT/Speech <input type="checkbox"/> Discharge summary (if available) 3 days of latest progress report <input type="checkbox"/> Physician discharge order (to include follow up orders, etc.) <input type="checkbox"/> I updated the chart copy updated on day of discharge _____ (initial)	
DNACM _____ Date/Time _____	
Unit Secretary:	
Discharge summary was sent on the day of discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No	
LS _____ Date/Time _____	

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## DISCHARGE I-FORM

Discharge
AMMISTAR, R  
434
likeOrders

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**Day of Discharge Orders**

Discharge To:

Discharge Diagnosis:

Conditional On:

Comments:

Other Instructions:

**Med**

Consistent Care:  1900 cal\_w

Low Cholesterol:

Low Sodium:

Resume Home Diet:

Other:

**Instructions**

Discontinue IV:

Prescriptions Written:

See DIC Medication Reconciliation:

Imaging:

Past Discharge Imaging Order:

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**Discharge Referral** [Click here to enter referral](#)

Appointment With:

Dr:  Action:  Without:  Discharge Referral:

Dr:  Action:  Without:  Discharge Referral:

Dr:  Action:  Without:  Discharge Referral:

**Discharge Referral**

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**Discharge Referral**

Discharge Referral:

Discharge Referral:

Discharge Referral:

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Complain
Misc # of com
07/13/2016 13:38
Place Orders
Start Over
Exit Without Ordering

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AMMISTAR, R  
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**Discharge Referral**

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Complain
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07/13/2016 13:38
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## New EMC-SNF Transfer Communication Process/Outcomes



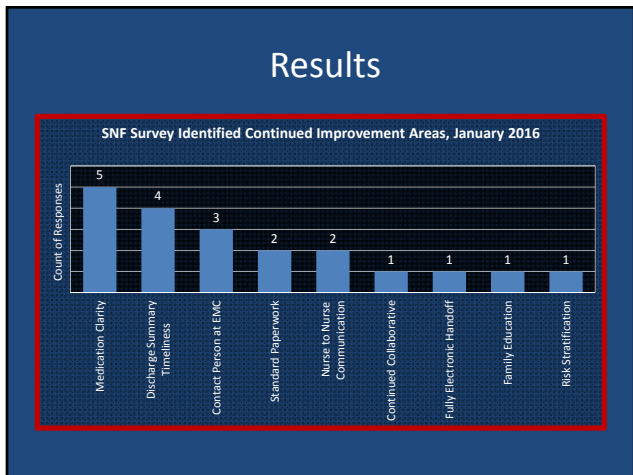
Created an environment for increased dialogue and positive cooperation between the organizations and among care team members

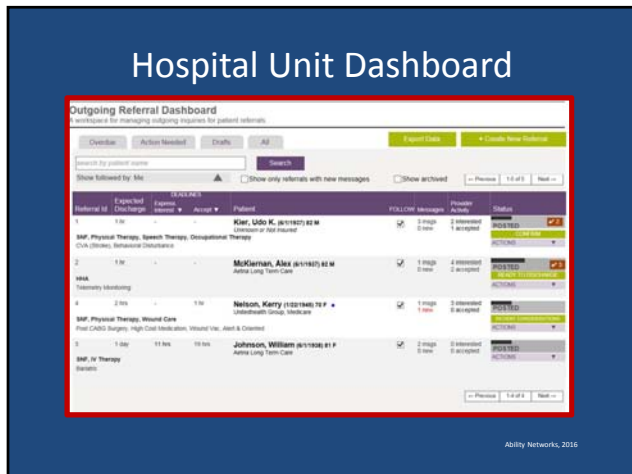
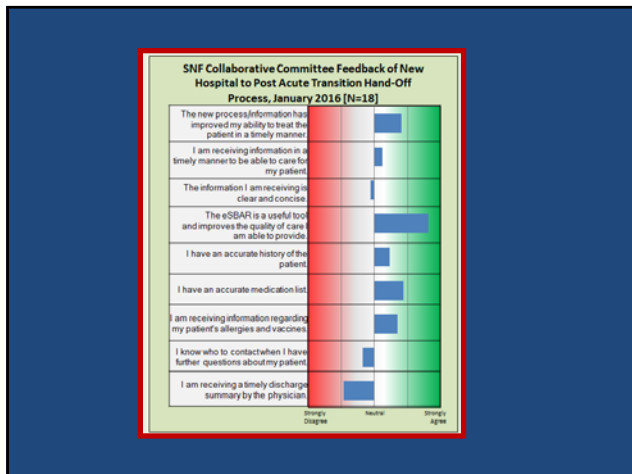
More effective communication & more efficient tools resulted in:

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



**FEEDBACK**





- ### 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 every day practice in long-term care facilities.”

## INTERACT Nursing Home to Hospital Transfer Form

**Nursing Home to Hospital Transfer Form**  
Version 4.0 Tool

**Resident Name** (Last, first, middle initial) \_\_\_\_\_  
 Language:  English  Other \_\_\_\_\_ Resident in:  SNF  Hospital  Long-term care  
 Date Admitted (last month) \_\_\_\_\_ SNF \_\_\_\_\_ Hospital \_\_\_\_\_  
 Primary diagnosis for admission \_\_\_\_\_ SNF \_\_\_\_\_ Hospital \_\_\_\_\_

**Contact Person**  
 Relationship (check all that apply):  Relative  Healthcare proxy  Guardian  Other \_\_\_\_\_  
 Name/Title \_\_\_\_\_  
 Tel. # \_\_\_\_\_  
 Address \_\_\_\_\_  
 Primary Care Physician in Nursing Home:  NMD  NMP  NPH  
 Name/Title \_\_\_\_\_  
 Tel. # \_\_\_\_\_

**Code Status**:  Full Code  DNR  DNI  DNI/DNR  Comfort Care Only  Unknown

**Key Clinical Information**  
 Reason for transfer: \_\_\_\_\_  
 Is the primary reason for transfer for diagnosis, testing, not addressed?  No  Yes Note: \_\_\_\_\_  
 Admission diagnosis:  SNF  SNF/D  SNF  SNF  SNF (to further treatment)  Unknown  Other \_\_\_\_\_  
 SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_  
 Other acute pain issue: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_  
 Other acute pain issue: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_ SNF/Date: \_\_\_\_\_

**Staff/Functional Status**:  Staff  Functional Status:  Independent  Dependent

**Additional Clinical Information**:  
 Other relevant history information  Other relevant information  Other relevant information

Interact, 2014

## 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



West Healthcare, 2016

## Four High Impact Areas

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



## Acknowledgements

EMC expresses its appreciation to individuals and organizations that share their insights with us.

Brookdale  
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The Fountains at the Carlotta  
Indio Nursing and Rehab  
HCR Manor Care  
Monterey Palms  
Premier Health Care  
Rancho Mirage Health Care

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## That's Enough

Thanks for listening!

