Innovation in Indianapolis

A Model for Regional Collaboration to Improve Patient Safety

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“The Indianapolis Coalition for Patient Safety is a prime example of how collaboration is accelerating change...among very competitive organizations (and) is a national model for community-based process improvement...”

—Don Berwick, IHI President and CEO
Objectives

- Describe 2 benefits of collaborating to improve patient care and safety.
- Define 3 minimum care standards for Heart Failure (HF) patients.
- State the intended purpose of the "Dear SNF Administrator Letter".
- Define the primary reasons for the pilot to improve hospital to SNF, nurse to nurse verbal communications.

Case Examples
What Happens Next??

• 85 yo white female admitted to a SNF after a hip replacement
• PMH: HTN, backache, anemia and cardiomyopathy
• Her pain is controlled but appetite is poor
• Physician sees her and allows her to have her family to bring outside food
• One week later, patient is confused with 7 pound weight gain
• The physician is called but he was “just there”. He will plan to stop by tomorrow afternoon.
• What happened with her?

What Happens Next??

• 77 yo AA female returned to a SNF after a heart failure exacerbation
• PMH: diabetes, stage III chronic kidney disease
• SCr rose to 3.7 during hospitalization and Lasix put on hold.
• Upon discharge, renal insufficiency is resolving. Discharge orders for physician to resume diuretic in SNF.
• Lasix not restarted.
• Two days later patient starts to have difficulty breathing. Unknown if weight gain b/c no weight taken.
• The physician is called. Nurse attained order to restart Lasix but not available to the nurse for another 4 hours.
• What happened with her?
What Happens Next??

- 82 yo AA male admitted to a rehab facility after a 5 day hospitalization for pneumonia & heart failure
- PMH: HTN, cardiomyopathy-stage III diastolic dysfunction
- Patient had been gaining strength over next 2 weeks. Plans were being made for discharge home soon.
- Patient developed sudden onset of shortness of breath at 2am on day 13 - flash pulmonary edema. *Facility reports that it “came on suddenly”.*
- In hindsight,
  - Patient had been requiring that the head of the bed be elevated more to sleep,
  - Complained that he didn’t have much appetite recently, and
  - Stated that he was going to have to go shopping soon because his shoes and pants were getting tight.

- What happened with him?

Heart Failure - Significance

- Affects 5.8 million people in America
- Responsible for 46,000 deaths every year
- Incidence of 670,000 new cases annually
- Most common hospital diagnosis > age 65
  - *Condition of the elderly*
- Annual cost of $39.7 billion
  - More $$ spent on heart failure than any other Medicare diagnosis
- All-cause 30-day readmission rate = 24%
Members and Collaborators:

- Marion County Health Department
- Indiana Hospital Association
- Deans of Medical, RN & Pharm Schools
- HealthCare Excel (QIO)
- Eli Lilly
- Indiana State Dept. of Health
- Franciscan St. Francis
- Anthem WellPoint
- IHIE (RHIO)
- Regenstrief Institutes
- St. Vincent
- IU Health
- Collaborate for Patient Safety
- Community

We will not compete on safety and will share openly best practice.

Coalition Heart Failure 30-day Readmission Rate

20 Central Indiana Hospitals

Average Rate = 15.7%
All Cause Readmission
HEART FAILURE DRIVERS OF READMISSIONS

Harm During Admission
- Hospital Acquired Conditions:
  - Surgical Site Infection
  - Blood Borne Infection
  - Urinary Cath Infection
  - Vent Acquired Pneumonia
- Unreliable handoffs:
  - Inpatient to Outpatient
  - Hospital to Doctor
  - Hospital to Home

Patient Co-morbidities & Demographics
- Co-Morbidity:
  - COPD
  - Diabetes
  - Asthma
  - Cancer
- Demographics:
  - Race
  - Ethnicity
  - Language

Patient Acceptance:
- Home Health
- Surveillance/Monitoring
- Medication and Tx

Errors in Care Transitions
- Med Access/Cost & Follow up
- Homecare Referral
- Signs/Symptoms

Patient Compliance

SNF HF 30-Day Readmission Rate
for any reason

Between July-December 2011
- 322 HF patients discharged to a SNF at the end of their heart failure acute hospitalization
- 57 readmitted back to a hospital within 30 days.
  Readmission Rate from SNF = 17.7%

Source: Data for Central Indiana Coalition Hospitals, Indiana Hospital Association 2012
Coalition HF Readmission Team
Current SNF Initiatives

Expand Skilled Nursing Facility (SNF) collaborations:
– Minimum care standards for HF patients residing in SNF/LTAC
– Hospital to SNF/LTAC verbal hand-off communications

Heart Failure Patients in SNFs

• Growing Population
  – Three times more discharges to non-home venues past 10 years
  – 20-24% Medicare HF discharges to SNFs

• Do they have Fewer Readmissions?
  – Patients discharged to extended care facilities are readmitted MORE within 30 days (28.2% vs. 23.7%)

• Do they have Improved Outcomes?
  – 76% increased risk of death
**Problem Identified**

- Inadequate continuity of care and communication
- Physician visits may not take place for days or weeks
- Inaccurate and/or infrequent weights
- Medication delays
- Lack of availability of 2 GM Sodium diet
- Lack of Heart Failure trained staff

**Determining Minimum Standards**

- **Challenges:**
  - Scientific evidence is limited
  - Evidence is not robust e.g. no controlled trials etc.
- **Sources:**
  - Available HF care evidence
  - AMDA Clinical Practice Guidelines
  - Transitional care evidence
  - IMDA Board members
Some examples of Published SNF HF care Initiatives

• Use of HF Care Coordinators:
  – Hospital RNs called facilities within 48 hrs and focused on care efficiency, prevention of med errors, daily weights, diet, physician follow up and diuretics
• Use of interdisciplinary teams that implemented HF protocols
• Focus on preventative strategies including vaccinations
• Use of educators to for patients and monitor weights

The Minimum Requirement

• Request received from ICPS
• Created first draft
• Vetted by the Indiana Medical Directors Association board members
• Presented to the ICPS
• Discussions and compromises to reach the final document
SNF HF Care: Minimum Standards

1. Best Practices in HF Transitional Care:
   a. Medication Reconciliation
   b. Discharge Summary in chart within 72 hours of admission
   c. Clarification of code status within 24 hours of admission
   d. Initial plan of care goals within 72 hours of admission
2. Low salt diet (2 grams/day)
3. Daily weights for 30 days and then 3 times per week thereafter
4. Initial provider visit within 48 hours of admission and at least weekly follow-up visits
5. Activity as tolerated outside of therapy
6. HF champion within the facility (leads the quality improvement efforts; implements systems for patient and family HF education)

Why these Standards

• “Most bang for the buck”
• Address common but critical gaps in HF care
• Daily weights and low-Sodium diet are the core principles of HF care
• HF Champion:
  – Recognize HF in the patient charts
  – Implements policies to help meet standards of care and patient hand-offs
  – Leads patient and family education initiatives
• Consistent clinician follow-up is critical for ongoing HF management
A Call for Commitment

Letter of Invitation, Commitment & Implementation

Rebecca Bartle, RN, MSN, HFA
Hoosier Owners and Providers for the Elderly

“Commit”

• to entrust
• to charge
• to do/perform
Expectation

• The facility will review the standards with the Medical Director and adopt the standards as practice/protocol for the HF resident(s).

HF Champion

• An individual designated by the facility
  – Available to serve as contact person should the hospital representative desire further information regarding a resident discharged from the hospital and admitted to a facility partner
  – Committed to lead the quality improvement efforts for enhanced HF care and implement systems for patient and family education regarding Heart Failure
Purpose of the Commitment

• Foster ongoing communication and collaboration between the discharging hospital and the admitting facility

Keep Information Current

• Administrator
• Medical Director
• Heart Failure Champion
Pilot to Improve Nurse to Nurse Verbal Communications during Patient Transfer from Hospital to SNF

Andrea Osborne, HFA, American Senior Communities

Baseline Survey

“Sender” Communications Survey
– Survey targeted to hospital nursing staff

“Receiver” Communications Survey
– Survey targeted to Skilled Nursing Facility staff (SNF)
“Sender”/”Receiver" Survey Content

- Timeliness of Communication
- Content of Hand-off (relevant information)
- Appropriate people involved
- Setting (minimal interruptions during hand-off)
- My questions/concerns were addressed
- Did a “near miss” or “adverse event” occur related to this hand-off and why?

Survey Process

6 Indianapolis Health Systems completed 25 “sender” communications surveys

4 Central Indiana companies completed 26 “receiver” communications surveys

Additional verbal feedback solicited
“Sender” (Hospital) Survey Results

Hospital nurses perceive that they are communicating relevant information in a timely manner.
However….

Patient Specific Information Needed Varies between Hospital and SNF

<table>
<thead>
<tr>
<th>Important to the hospital</th>
<th>Important to the SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Status</td>
<td>Bowel Movements</td>
</tr>
<tr>
<td>Medication list</td>
<td>Transfer status</td>
</tr>
<tr>
<td>Diagnosis history</td>
<td>Decision Making ability</td>
</tr>
<tr>
<td></td>
<td>Last Meal</td>
</tr>
</tbody>
</table>
“Receiver” (SNF) Results

In all instances patient arrived after report was called, although nurses report issues of call coming after patient arrives on occasion.

When reports were called:
   Before Noon: 5
   Noon to 4pm: 8
   After 4 pm: 13

“Receiver” (SNF) Results

Communication Issues:
   No diagnosis with meds (requirement for SNF)
   Missing diagnosis x 4
   Lack of current status x 3
   No code status
   Lack of recent changes x 3
   Immunizations not sent
   No relay of concerns/heads up x 4
   Lack of plan of care x 3
   Inability to communicate back with sender x 3
   Missing key or incomplete clinical information
“Receiver” (SNF) Results

Unwanted patient outcomes that could have been related to hospital to SNF communications issues:

- Falls x 2
- Delay in diagnosis or treatment
- Need for additional testing x 2
- Need for additional monitoring x 2
- Transfer back to hospital
- Adverse patient experience

SNF Clinical Leaders Create “Cue Card”

to Improve Hand-Off Communications from Hospital to SNF

- Admitting Diagnosis / Focused patient history
- Abnormal Labs/tests/Vitals
- Skin issues and treatments with frequency
- Current Medications
- Safety precautions (anticipatory concerns)
- Diet restrictions or feeding precautions
- Cognition/Behaviors
- Code Status

Additional Family/Patient information that may affect transfer or stay
Piloting the “Cue Card”

- 6 nursing units across 6 Indianapolis Health Systems
- 5 SNF companies using multiple facilities involved
- Remeasure using “Sender” and “Receiver” communication survey tools (pilot results available October 2012)
- Goal: spread use of “Cue Card” to all nursing units in Indianapolis hospitals and all Indianapolis area SNFs

Panel Discussion
Conclusions

• Better HF care will need a new collaborative culture, centered on patient safety
• Minimum care standards aim to address basic gaps in SNF HF care
• Signing the “Dear SNF Administrator Letter” displays facility commitment to better HF care
• Innovative and formal systems like the use of the “cue card” will be needed to enhance hospital to SNF, nurse to nurse verbal communications.
Nursing Facility Verbal Handoff Cue Card

Provide a complete and concise report on the patient that allows the accepting nurse to provide care until written report is able to be reviewed.

IDENTIFYING INFORMATION

- Name
- DOB
- Language
- Male/Female
- Hospital Admission Date

CURRENT MEDICAL INFORMATION – Pertinent information

- Admitting Diagnosis
- Focused patient history
- Co-Morbidities of relevance
- Surgery Hx of relevance
- Abnormal Labs or diagnostic test results
- Abnormal Vital Signs
- Current Weight (bariatric equipment)
- Skin issues and treatments with frequency
- Current Medications
  - Review critical meds
  - Next time of dosing
  - not including supplements and vitamins
- Invasive lines, location, use
- Safety precautions (anticipatory concerns)
  - Allergies
  - Fall risk
  - Infection control status
- Diet restrictions or feeding precautions
- Cognition/Behaviors
- Code Status (Does patient have Out of Hospital DNR)
- Additional Family/patient information that may affect transfer or stay
- Give Number to call back if questions and name of on-coming nurse

Conclude by giving the receiving staff person the opportunity to ask any questions or clarify information. Remember to send scripts for narcotics.
TO: Administrator

FROM: Arif Nazir, MD, Past President, Indiana Medical Directors Association
Glenn Bingle, MD, Chair, Indianapolis Coalition for Patient Safety
Carol Birk, President, Indianapolis Coalition for Patient Safety
Heart Failure Patient / Skilled Nursing Facility Work group (HF/SNF/LTC) Members

DATE:

RE: Minimum Care Standards for Heart Failure (HF) Patients residing in Central Indiana Skilled Nursing and Long Term Care Facilities

The Indianapolis Coalition for Patient Safety was formed in 2003 with the mission of making the greater Indianapolis area a safer community in which to receive healthcare in the hospital setting. The membership includes IU Health, Community Health Network, Franciscan-St Francis Health, St. Vincent Health, Wishard Health Services, Roudebush VA Medical Center and the Suburban Health Organization member hospitals.

During 2011, the Coalition formed a HF/SNF/LTC work group to address care transitions of Heart Failure patients from hospital to SNF because 30 day Heart Failure patient hospital readmissions for all cause readmissions within our Coalition hospitals averages 15.7% where HF is the principal diagnosis.

Development of minimum care standards for the HF patient residing in a SNF/LTC facility is one of many approaches to address prevention of Heart Failure patient readmissions to hospitals. The initial action of the work group was to come to consensus on minimum standards of care for the Heart Failure (HF) patient. The standards listed below were drafted by Dr Arif Nazir, Past President, Indiana Medical Directors Association, using the available evidence in the scientific literature and the guidelines from the American Medical Directors Association, and were subsequently discussed and supported by our work group members.

1. Best Practices in Transition of HF Patients:
   a. Medication Reconciliation (focus on diuretic, beta-blocker, ACE-Inhibitor, and antiplatelet therapy)
   b. Discharge Summary available in the chart within 72 hours of admission
   c. Clarification of code status within 24 hours of admission
   d. Initial plan of care goals within 72 hours of admission
2. Availability of a low salt diet (2 grams/day)
3. Daily weights for 30 days and then 3 times per week thereafter
4. Initial provider visit within 48 hours of admission and at least weekly follow-up visits
5. Activity as tolerated outside of therapy
6. Identify a HF champion within the facility who leads the quality improvement efforts for enhanced HF care and implements systems for patient and family education regarding HF.
Following the development of the care standards, the next action of the workgroup is to identify facilities which will commit to implement them. The expectation would be the facility would review the standards with the Medical Director and adopt the standards as practice/protocol for the HF resident(s).

We plan to create and share with Coalition hospitals a list of SNFs and LTCs supporting these minimum care standards for HF patients. When giving agreement to support the standards, the facility is requested to identify an individual who will serve as “HF champion,” who will be available to serve as the contact person should the hospital representative desire further information regarding a resident with heart failure who has been discharged and admitted to the partner facility. The HF champion will lead the quality improvement efforts for enhanced HF care and implement systems for patient and family education regarding Heart Failure.

The purpose in requesting a commitment to upholding the HF care standards is to foster ongoing communication and collaboration between the discharging hospital and the admitting facility. If your facility is willing to accept the standards in an effort to promote the prevention of Heart Failure patient readmissions to hospitals, we ask that you provide the necessary information at the bottom of this letter and email to Carol Birk, cbirk@indypatientsafety.org. This will indicate support by your organization/facility of the listed minimum care standards for Heart Failure patients.

We look forward to your support of these care standards, and your willingness to unite with us in this effort to continue making Indianapolis a safe place to receive healthcare. Should you have any questions regarding these standards, please contact the Arif Nazir, MD anazir@iupui.edu, or Glenn Bingle, MD, gbingle@indypatientsafety.org, Indianapolis Coalition for Patient Safety.

Facility Name __________________________________________   Date ___________________

Address _______________________________________________  

Administrator Name (Print) ___________________________ (Sign) ____________________________

Contact telephone ( ) _________________________________

Medical Director Name (Print) _________________________ (Sign) ____________________________

Heart Failure Champion Name (Print) ________________ (Sign) ____________________________

Contact Telephone/Ext __________________ E-Mail___________________________________

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