ACGME Institutional Requirements

- III.B.3. Transitions of care: The Sponsoring Institution must:
  
  - III.B.3.a) facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, (Core)
  
  - III.B.3.b) ensure that participating sites engage residents/fellows in standardized transitions of care consistent with the setting and type of patient care. (Core)
OMC - CLER Readiness Assessment

<table>
<thead>
<tr>
<th>CLER Focus Areas</th>
<th>Self Assessment Gap Analysis</th>
<th>Post CLER site visit comments</th>
</tr>
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<tbody>
<tr>
<td><strong>PATIENT SAFETY</strong></td>
<td></td>
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<tr>
<td>Trainee reporting of errors, etc.</td>
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<td>yellow</td>
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<tr>
<td>Participation in interprofessional teams</td>
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<tr>
<td><strong>QUALITY IMPROVEMENT</strong></td>
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<tr>
<td>SI engages trainees use of data to ↑quality</td>
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<td>SI engages trainees use of data to ↓disparities</td>
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<tr>
<td>SI engages trainees use of data to ID &amp; ↓disparities</td>
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<tr>
<td><strong>TRANSITIONS IN CARE</strong></td>
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<tr>
<td>SI standardization/oversight of transitions of care</td>
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<tr>
<td><strong>SUPERVISION</strong></td>
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<tr>
<td>SI oversight in line with ACGME</td>
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<td>yellow</td>
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<tr>
<td>Program oversight in line with ACGME</td>
<td>yellow</td>
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</tr>
<tr>
<td><strong>DUTY HOURS/FATIGUE</strong></td>
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<tr>
<td>SI oversight of Duty Hours</td>
<td>yellow</td>
<td>yellow</td>
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<tr>
<td>SI mitigating fatigue</td>
<td>yellow</td>
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<tr>
<td>SI educates Faculty/Trainees</td>
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<td><strong>PROFESSIONALISM</strong></td>
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<tr>
<td>Educate/Monitor Trainees</td>
<td>yellow</td>
<td>yellow</td>
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<tr>
<td>Educate/Monitor Faculty</td>
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</tbody>
</table>
Why a National Initiative

- Collaboration with some of the best Independent Academic Centers in the Country
- Sharing of best practices and lessons learned
- Access to National Leaders and Experts in performance improvement and patient safety
- Scholarly Activity

National Initiative IV Needs Statement:

- Lack of standard process between:
  - Inpatient settings
  - Hospital Based and Primary Care
  - Provider to Provider
  - Inpatient to extended / home care

- Evidenced by:
  - Patient safety metrics
  - Readmissions
  - Patient lost to follow up with unknown outcomes

Team Charter
What we have committed to do

To evaluate current practices, define best practices and implement a standardized approach to transitions of care, specifically resident to resident hand-overs.
A Review of What We Have Learned

Duty Hour restrictions increase hand offs

Each hand off creates a point of vulnerability in exchange of data, understanding and responsibility between physicians

Research: breakdown in information transfer creates discontinuity of care and has a negative impact on patient safety
- Delay in test ordering
- Excessive test ordering
- Medication errors
- Increased length of stay
- Decreased efficiency of the individual and the system

Findings to date: Strong adoption and utilization in areas where we have significant focus and buy in from Resident and Faculty Champions. Need continued work with faculty to establish as part of routine curriculum, assessment and feedback processes

Logic would suggest:

More effective hand off systems = Decrease in error and adverse events

Standardized and formalized processes of information transfer are more effective
The Underlying Model: iPass

**I** Illness Severity -- Stable, “Watcher”, Unstable

**P** Patient Summary - events leading up to admission, hospital/operative course, assessment and plan

**A** Action list – to do list, timeline and ownership

**S** Situation Awareness & Contingency Plan - Know what’s going on; plan for what may happen --- If / Then

**S** Synthesis by Receiver - receiver summarizes what was heard, asks questions; restates key actions / to do items

Global Elements of Effective Handoffs:

Unambiguous transfer of Information & Responsibility, Protected Time and Space, Standardized Format

<table>
<thead>
<tr>
<th>Verbal</th>
<th>Tool/ Written</th>
</tr>
</thead>
</table>
| Complements Tool
  - Structured Format – High level overview
  - Appropriate Pace
  - Closed loop communication
    - Solicit check backs
    - Non-verbal | Electronic Tool the foundation
  - Content / Length
    - Level of training
    - Knowledge of pts
    - Length of time on rotation
  - Opportunity for Discussion creates shared mental model and facilitates active participation by both parties |
The Structured Tool - EPIC

- Supplements the verbal handoff
  - Allows receiver to follow
  - Provides more comprehensive information

- Creates efficient information transfer

- Requires routine updates
  - High-quality information
    - Don’t copy and paste
  - Mentor (Sr resident / supervising faculty) should edit when necessary to assure quality
  - Incorporate time for review and update into daily workflow
  - Note updates are time stamped and identified

<table>
<thead>
<tr>
<th>Room Number:</th>
<th>MRN:</th>
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</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Allergies:</td>
</tr>
<tr>
<td>Age:</td>
<td>Admit Date:</td>
</tr>
<tr>
<td>Sex:</td>
<td>BMI:</td>
</tr>
<tr>
<td>Code Status:</td>
<td></td>
</tr>
</tbody>
</table>

Illness Level (current clinical status): Watcher - [YES/NO/21869]
Reason for Admission: [ PATIENT REFERRAL / MEDICAL]
Brief HPI (pertinent PMH and diagnosis or differential diagnosis): ***
Procedure Date: ***
Hospital Course (updated, brief assessment by system or problem, significant events): ***
Tasks (specific, using if-then statements): ***
Contingency Plan (special circumstances anticipated and plan): ***
Estimated Discharge Date: ***
Discharge Disposition: [IP DISCHARGE DISPOSITION: 364001000: "Home or Self Care"]
Mentored By: ***
Resident Handoff

Primary Team: Team X
Room Number: 500

Date of Birth: 1/01/1964
Allergies: penicillin

Age: 60
Admit Date: 07/01/2014

Sex: M
BMI: 52

Code Status: Full

Illness level (current clinical status): WATCHER (Unstable)

Reason for admission: Severe sepsis

Brief HPI (pertinent PMH and diagnosis or differential diagnosis):
60yo M with past medical history of DM2, CAD, CHF (EF=40%), AF, and COPD who presents with gradually worsening SOB, cough productive of yellow sputum, increased swelling of lower extremities. Increased use of home O2 (baseline of 2L)

Hospital Course (Updated brief assessment by system or problem, significant events):
1. Severe Sepsis: Admitted with ¾ SIRS (febrile to 102, HR 110, RR 22) with AMS and AKI. Patient is alert and communicative (sometimes inappropriate) currently.
2. COPD exacerbation: Global wheezing on presentation, Obtaining solumedrol 125 Q8H, Duonebs Q4H, Moxifloxacin (day 2). On 50% Venti Mask currently.
3. AKI: BUN/creat of 40/2.5 with a baseline of 1.3.

Tasks (specific, using if, then statements):

- If patient is febrile overnight, please recollect blood cultures, urine cultures, urinalysis.
- If patient becomes hypotensive (SBP <100), please bolus patient 500cc fluid at a time. Be cautious of respiratory status as patient does have a history of CHF.
- If patient becomes agitated, may give zyprexa 10mg IM.

Contingency Plan (special circumstances anticipated and plan):
Plan: Continue steroids/duonebs/antibiotics while weaning down O2 requirements. Notify ICU if acute change in respiratory status or worsening BP unresponsive to IVF.

Tips on Observing the Handoff

- Set the stage and establish objectives
  - Establish the importance of direct observation
  - Review the elements that are being observed
  - Remind participants that this is formative feedback
- Listen and observe
- Attempt not to interrupt unless a patient safety issue arises
- Debrief
  - Optimally done immediately or within 24 hours of observation
  - Best if done in person so that dialogue is possible

Ochsner Health System
I-PASS Study – Handoff Assessment

Enter the I-PASS password

Verbal Handoff Assessment  Faculty Observation-Feedback: GIVER

Verbal Handoff Assessment  Faculty Observation-Feedback: RECEIVER

Printed Handoff Document Assessment  Faculty Observation and Feedback Tool

Ochsner
Health System

I-Pass Study
Verbal Handoff Assessment
Faculty Observation and Feedback Tool for GIVER

Observer Information
Observer Name:  
Observation Start Time: HH:MM:SS  Observation Date: MM/DD/YYYY
Observation End Time: HH:MM:SS

[Blank]

How well do you know the patients whose handoff you are evaluating?
○ Very well  ○ Somewhat well  ○ Not at all

Resident Information
Service:  PGY:  Patients discussed: 

Type of Handoff
1. Type of handoff you observed: ○ Individual  ○ Team

Situational Overview (Big Picture)
2. Was a situational overview provided by the resident giving the handoff (e.g. description of the “big picture” of what will need to be prioritized by the receivers of the handoff):
○ Yes  ○ No

Ochsner
Health System
### Indicate the frequency that the specific element of the mnemonic was used throughout the handoff.

<table>
<thead>
<tr>
<th>Verbal Mnemonic</th>
<th>Description</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Illness Severity</td>
<td>Identification as stable, &quot;watcher&quot;, or unstable</td>
<td></td>
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<tr>
<td>4. Patient Summary</td>
<td>Summary statement, events leading up to admission, hospital course, ongoing assessment, plan</td>
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<td></td>
<td></td>
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<tr>
<td>5. Action List</td>
<td>To do list, timeline and ownership</td>
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</tr>
<tr>
<td>6. Situation Awareness/Contingency Planning</td>
<td>Know what's going on; plan for what might happen</td>
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<tr>
<td>7. Synthesis by Receiver</td>
<td>Ensures receiver summarizes what was heard, asks questions, restates key actions to do items</td>
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</tr>
</tbody>
</table>

### Rate the frequency with which the resident who gave the handoff did the following:

| 8. Actively engages receiver to ensure shared understanding of patients (Encouraged questions, asked questions, considers learning style of receiver) | Never | Rarely | Sometimes | Usually | Always |
| 9. Appropriately prioritizes key information, concerns, or actions                                               |       |        |           |         |        |

### Rate the frequency with which the resident who gave the handoff did the following:

| 10. Miscommunications or transfer of erroneous information | Never | Rarely | Occasionally | Fairly Often | Very Often |
| 11. Omissions of important information                     | Never | Rarely | Occasionally | Fairly Often | Very Often |
| 12. Tangential or unrelated conversation                    | Never | Rarely | Occasionally | Fairly Often | Very Often |

### Rate your overall impression of the pace of the handoff:

- Very slow pace / Very inefficient
- Slow pace / Inefficient
- Optimally paced / Efficient - not rushed
- Fast / pressured pace
- Very Fast / pressured pace

### 13. What was especially effective about the handoff?

### 14. What aspect(s) of the handoff could be improved?

### 15. Additional comments:

### 16. Was the resident given feedback within 24 hours of your observation?

- Yes
- No
Progress to Date: Transitions of Care

- Collaborative project with Alliance of Academic Medical Centers: National Initiative IV
- Focus on Clinical Learning Environment (CLE) component: transitions of care

- Began October, 2013 – to date:
  - Literature review to identify best practices - iPass – Boston Children’s Hospital built on TEAM STEPPS model
  - Internally identified lack of standardization, lack of mentorship of the process, leading to redundancy, dropped hand offs, lack of continuity in care - difficult to ascertain specific data, however moving to an electronic note understanding of the process will improve over time as we capture relevant information
  - HIM approved the note type
  - Frame work and template for form developed in with EPIC builders
  - Implementation, June 23, 2014
  - Observation process established August, 2014
  - Program by Program introduction to process
  - Form amended based on House Staff feedback: added procedure / delivery date and anticipated discharge date, Advanced Practice Clinicians access established
  - Ongoing faculty development and plan for increased mentoring of the process

Challenges and Barriers

- Beware of the “Brick Walls”
- Access and performance within the context of IT security
- Buy-in to the standardized approach
- Reaching everyone involved with the same level of information
- Parallel, redundant processes that tap same resources
- Individualized program roll-out
Next Steps

- Ongoing education and faculty development
- Ongoing faculty engagement
- Customizing smart phrases
- Incorporate into initial EPIC training
- Interprofessional engagement
- Continued cycles of improvement

Process Application Exercise
In Conclusion

We welcome you thoughts and feedback

Any Questions or Comments

ramedee@ochsner.org
jpiazza@ochsner.org

References

9. I-PASS Program. Children’s Hospital Boston. jpass.study@childrens.harvard.edu