Bridging the Gaps:
Improving the Safety and Quality of Transitions of Care

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Bridging the “gap” in care transitions

The “gaps” are everywhere....
Looking at the numbers

- 2013: An average of 282 per 1000 Medicare beneficiaries were hospitalized at least once (this is a total of 14.7 million people!)
- CMS/HHS statistics show that the 2013 readmission rate was 17.5%*
- This means that approx. 2.6 million people were readmitted to the hospital (at least once) in 2013

Problems that Create the “Gaps”

Results from several studies: 80 percent of serious medical errors/adverse events involve miscommunication between caregivers involved in care transitions

- Most common events include:
  - Medication errors (various types) – all ages
  - Wound infection
  - For elderly: falls/injuries, caregiver burden, nursing home placement and increased health care costs

- These often lead to:
  - Hospital readmissions (~20% of all Medicare patients)
  - Frequent ED visits, return visits

Video:

“Discharge Planning”

http://www.youtube.com/watch?v=Un7A3YR2-HU
Readmissions and Adverse Events

- Of the 20% of patients that are readmitted, several studies have shown that approximately half of these readmissions can and should be avoided.
- OIG Report on the rate of adverse events among hospitalized Medicare beneficiaries.
- 14% of hospitalized beneficiaries experienced an adverse event after hospital discharge (e.g., delirium, pressure sore, infection, or medication error—the routine, well-documented hazards of hospitalization for older people) that was likely preventable.

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Human Factors</th>
<th>Communication</th>
<th>Leadership</th>
<th>Assessment</th>
<th>Information Management</th>
<th>Physical Environment</th>
<th>Care Planning</th>
<th>Continuum of Care</th>
<th>Medication Use</th>
<th>Operative Care</th>
<th>Information Management</th>
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<td>2013</td>
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<td>142</td>
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The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

(*Note: It is believed that only about 2% of actual Sentinel Events are reported to The Joint Commission.)

ToC: Supported by the TJC Enterprise

- Accredited programs:
  - AHC Primary Care Medical Home
  - NCC Post-Acute and Memory Care programs
- Advanced Certification programs:
  - CHF, CSL, PSG, ASRH, PC, Perinatal, TNOR
- CTH: Hand-off Communications, Preventable Hospitalizations (CHF)
- Transitions of Care
- JCR: Publications and Consulting Services
- Accredited programs:
  - HC Community-based Palliative Care Certification
  - BHC Medical Home
  - Integrated Care Certification
Center for Transforming Healthcare (CTH)
Hand-off Communications Project

- Beginning in 2009, The CTH collaborated with 10 hospitals and health systems to begin a project focused on ineffective hand-off communications.
- For this project, a successful hand-off is defined as a transfer and acceptance of responsibility for patient care that is achieved through effective communication.
- Involves “senders,” and “receivers” of patient information
- Organizations examined the hand-off communications problems in their own facilities, and identified their specific barriers and causes for failures
- Identified, implemented and validated solutions that improved their performance

Process Improvement

Usual approach: best practices, toolkits, protocols, checklists, “bundles”
- Typical best practice is “one-size-fits-all”
- Can produce modest improvement
- Difficult to get to zero
- Difficult to sustain

The “one-size-fits-all” approach works well only for simple problems that do not vary

Toughest problems are not simple

A New Way of Delivering Results

- Complex processes require more sophisticated problem-solving methods
- Three crucial and consistent findings:
  - Many causes of the same problem
  - Each cause requires a different strategy
  - Key causes differ from place to place
- The CTH Hand-off Communications project used Robust Process Improvement (RPI™) and developed the Targeted Solutions Tool (TST®), which was released in 2012
Hand-off Communications (HOC)
Targeted Solutions Tool (TST)

The TST® is an innovative online application that guides health care organizations through a step-by-step process to:
• Accurately measure their organization’s actual performance
• Identify their barriers to excellent performance
• Direct them to proven solutions that are customized to address their particular barriers

Center for Transforming Health Care
Hand-off Communications Project:
Participating Hospitals’ Characteristics
and Project Highlights

Ten hospitals involved in project; three looked at transitions from one setting to another.
The contributing factors to failed transitions of care were very similar between “internal” and “external” transitions.
Size of hospitals varied from less than 200 beds to more than 2200 beds.
Validated root causes for failed transitions:

COMMON TO ALL ORGANIZATIONS IN CTH HOC PROJECT:
• Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/issues, contact information.
• Other major causes identified:
  • Sender, who has little knowledge of patient, is handing off patient to receiver.
  • Culture does not promote successful hand-off, e.g. lack of teamwork and respect.
  • Expectations between sender and receiver differ.
## A Successful Hand-off is Critical

**SHARE**

### Standardize Critical Content
- Identify and share key information and critical elements about patients when talking with the receiver.
- Synthesize patient information from disparate sources before passing it on to the receiver.
- Develop and use key phrases to help standardized communications.

### Hardwire Within Your System
- Develop and use standardized forms, tools and methods, e.g., checklists, SBAR tool.
- Establish a workspace or setting that is conducive for sharing information about a patient, e.g., zone of silence.
- Ensure access to electronic medical records is available to all staff caring for the patient.
- Integrate process into electronic medical record application.

### Allow Opportunity to Ask Questions
- Use critical thinking skills when discussing a patient's case.
- Share and receive information as an interdisciplinary team, e.g., "pit crew.
- Expect to receive all key information and critical elements about the patient from the sender.
- Collect sender's contact information in the event there are follow-up questions.

### Reinforce Quality and Measurement
- Demonstrate leadership's commitment to implementing successful hand-offs.
- Utilize a sound measurement system to determine the real score in real time.
- Hold staff managing patient's care responsible.
- Monitor compliance of standardized form, tools and methods for hand-off between sender and receiver.

### Educate and Coach
- Teach staff on what constitutes a successful hand-off.
- Standardize training on how-to conduct a hand-off.
- Provide ongoing feedback and just-in-time training.
- Make successful hand-offs an organizational priority and performance expectation.

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### A Successful Hand-off is Critical


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### Hand-off Communications (HOC)
**Targeted Solutions Tool (TST)**

**Powered by RPI™**

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Enterprise-wide Strategic Planning Project:

Transitions of Care (2012-2014)

- Initial research of various models
- Review of current standards
- Development of ToC Portal
- Learning visits, expert panel
- Consideration of new standards
- Publications
- Surveyor education across programs
- Customer education across programs

Project Research and Outcomes

Foundations of Safe Transitions
Leadership oversight

Assigned accountability

Resource allocation

Collaboration with community partners

The team: all disciplines involved in patient/client care

The team includes the provider at the next setting

Patient/family is a member of the team

The team develops care goals

Use of “triggers” to identify high risk patients/clients early in the admission/intake process

Diagnosis

Multiple co-morbidities

Payor source

(example: uninsured)

Age
- Medication reconciliation
  - Engage family/caregivers
  - Call PCP
  - Contact pharmacy used by patient
- Patient/family education
- Consideration of financial resources
- Potential other barriers
  - Aging process: opening medication bottles, reading labels
  - Health literacy

- Should be proactive rather than reactive
- Early identification of those at risk
- Thorough psychosocial assessment
- Start discharge planning at admission/intake
- Interdisciplinary coordination
- Enhanced follow up care
  - Transportation, supplies, MD appointments, treatment appointments, home care, etc.

- Treatment team membership
- Learning style identification
- Knowledge deficit determined
- Educate! (“teach-back”)
- Patient/family commitment; responsibility/accountability for care
Notification of high risk patient/client to the multidisciplinary team.
Formalized processes for communication of information to next provider of care
Clear discharge instructions
Key information for next provider: diagnosis, treatment provided and response to care, medication information, support systems and resources, follow up care including appointments, treatments, outstanding labs/diagnostics, referrals given.

Project Outcomes
1) Development of ToC portal
   • Research and information gathered put in one place to share with customers and the public

Description
• The Transitions of Care (ToC) Portal website is a source of information on the topic of care transitions from one setting to another
• The portal is updated every 9 - 12 months.
Purpose of the ToC Portal

- The Portal was created to provide both our accredited customers and the public with a source of information on the topic of care transitions.
- The website provides various types of information: written articles, JCR products (free/for sale), the CTH Hand-off TST, educational materials, links to numerous websites, etc.

Target Audience

- The ToC portal is accessible by everyone!
- Information/links are provided for all our accreditation and certification programs that address transitions of care: HAP/CAH, OME, BHC, NCC, AHC, DSC

Accessing the Portal: Front Page
Page 2: Performance Measurement

- Accreditation
- Certification
- Standards
- Measurement
- Topics
- About Us
- Daily Update

Performance Measurement and ToC
- ToC Portal Content
  - New articles and publications added as of August 2014
  - Joint Commission Measures
    - Critical Path for Hospital
    - Improved QI and Performance Improvement
    - Effective Care Coordination/Teamwork
    - Non-CQI Guidance on Care Transitions - ACIP
    - NQF-Recommended Core Measures
    - NQF: Preventing Adverse Events in Health Care
    - NQF: Core Measures
  - Articles and Publications
  - Critical Path for Hospital
  - Improved QI and Performance Improvement
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  - Non-CQI Guidance on Care Transitions - ACIP
  - NQF-Recommended Core Measures
  - NQF: Preventing Adverse Events in Health Care
  - NQF: Core Measures

Page 3: Articles & Publications

- Accreditation
- Certification
- Standards
- Measurement
- Types
- About Us
- Daily Update

ToC Articles and Publications
- ToC Portal Content
  - New articles and publications added as of August 2014
  - Care Transitions Articles - JDC
    - Evidence-Based Strategies for Implementing Patient Centered Care Transitions
    - Care Transitions for Patients and Families
    - Care Transitions: Patient and Family Perspectives
    - A Model for Advanced Care Transitions Practice
  - Articles and Publications
    - Evidence-Based Strategies for Implementing Patient Centered Care Transitions
    - Care Transitions for Patients and Families
    - Care Transitions: Patient and Family Perspectives
    - A Model for Advanced Care Transitions Practice

Page 4: Publications by Provider

- Accreditation
- Certification
- Standards
- Measurement
- Types
- About Us
- Daily Update

Publications by Provider Type
- ToC Portal Content
  - Antibody Medical Care
    - Evidence-Based Strategies for Implementing Patient Centered Care Transitions
    - Care Transitions for Patients and Families
    - Care Transitions: Patient and Family Perspectives
    - A Model for Advanced Care Transitions Practice
  - Home Health Care
    - Evidence-Based Strategies for Implementing Patient Centered Care Transitions
    - Care Transitions for Patients and Families
    - Care Transitions: Patient and Family Perspectives
    - A Model for Advanced Care Transitions Practice
  - Nursing Care: Lumbar Pain
    - Evidence-Based Strategies for Implementing Patient Centered Care Transitions
    - Care Transitions for Patients and Families
    - Care Transitions: Patient and Family Perspectives
    - A Model for Advanced Care Transitions Practice
Please visit!

www.jointcommission.org/toc

You Can Help Build the Portal!

Help us provide resources to everyone who accesses the ToC Portal:

• Share new articles, publications
• Share helpful websites
• Share your organization’s ToC news
• Share your comments

cclark@jointcommission.org

Project Outcomes

1) Development of ToC portal
   ❖ Research and information gathered put in one place to share with customers and the public

2) Expert panel, focus group calls, and learning visits
   ❖ Assisted us to develop publications, and education for our customers, central office and field staff
   ❖ The research was used to further evaluate current standards as they relate to ToC
The Joint Commission Standards

Current Hospital standards that support the foundations of safe transitions of care

Standards meet or exceed the newest requirements at CMS Hospital CoP 482.43

Leadership Support

Allocation of resources

- LD.01.03.01 EP 5 - governing body provides resources
- LD.03.06.01 EP 3 - sufficient number and mix of staff
- LD.04.03.01 EP 2 - social work is an essential service

Provision of Qualified staff

- LD.03.06.01 EP 4,5 - those who work in the hospital are competent and adapt to change
- LD.04.01.05 EP 2 - programs/services are directed by qualified individuals
- LD.04.01.05 EP 5 - provide for the coordination of care, treatment, services among different … sites, services

Interdisciplinary Collaboration

- MS.03.01.01 EP 1 and 3 - physicians and psychologists manage and coordinate the patient’s care and there is coordination among the practitioners involved in the patient’s care
- PC.02.01.05 - care is provided in an interdisciplinary, collaborative manner

- PC.02.02.01 - coordinating care based on the patient’s needs, receiving and sharing of information
- PC.04.01.03 EP 3 - the treatment team(all involved in patient’s care, including family and patient) participate in planning d/c or transfer
Patient and Family Engagement

- PC.02.01.21 - effectively communicating with patients
- PC.02.03.01 - providing patient education and training based on assessed patient needs and abilities
- PC.04.01.03 EP 3 - the treatment team (all involved in patient’s care, including family and patient) participate in planning d/c or transfer
- PC.04.01.05 - before d/c or transfer, the hospital informs and educates the patient about follow-up care, tx, and services including written instructions in a manner the patient and family understand
- RI.01.01.01 - right to effective communication
- RI.01.02.01 - involving patient in care decisions
- RI.02.01.01 - patient responsibilities in care

Medication Management/Reconciliation

- NPSG.03.06.01 - maintain and communicate accurate patient medication information
- MM.01.01.01 - collect required patient information
- MM.04.01.01 - medication orders are clear and complete
- MM.05.01.01 - pharmacy reviews all medication orders

Early Identification of Those at Risk

- PC.01.02.01 - assess and reassess patients
- PC.01.02.03 - assessments completed at defined timeframes
- PC.01.02.09 - assessing risk of abuse or neglect
- PC.01.03.09 - planning care based on assessments and reassessments, plans and goals revised based on changing needs
- PC.02.01.01 - providing care based on the individualized plan of care
- PC.02.03.01 - providing education and training based on assessed needs and abilities
Transfer of Information

• PC.04.02.01 – at discharge or transfer, the hospital gives the next provider of care information about the care, treatment and services provided and the patient's progress towards goals

Effective Transitional Planning

• PC.04.01.03 - discharging the patient based on the assessed needs of the patient and the hospital's ability to meet those needs
  • -discharge planning begins early in the episode of care
  • -post discharge needs are identified
  • -prior to discharge, arrange or assist in arranging services required by the patient to meet the ongoing care needs
• RC 02.04.01 - document the discharge information to facilitate continuity of care

A new concept: Discharge to non-medical home care services

"Hospitals are seeing that a broader scope of services can be provided in the home, for longer periods of time and at a lower costs when home care is engaged as opposed to Medicare funded home health (in which home based services are restricted to "covered benefits")."

Hospitals, SNF’s Skipping Home Health - Partnering with "Home Care"
By Dr. Josh Luke, Adjunct Faculty, University of Southern California
Founder, National Bundled Payment Collaborative
NTOCC Spring 2016 Newsletter

• Hospitals and payers are contracting with private duty and non-medical home care providers to:
  • reduce spending
  • avoid a series of new penalties to hospitals and SNF’s if post acute spending exceeds national averages
Joint Commission Hospital Standards on Discharge Planning

To test your process and compliance with Joint Commission standards and CMS requirements, use the CMS Hospital Discharge Planning Survey Tool, released 11/14:


CMS Medicare Learning Network/Discharge Planning:

Home Care Standards Related to Transitions of Care

Assuring a safe environment of care for transitioning patients:
EC.02.01.01, 02.03.01

Assuring that there are qualified, educated staff to provide care:
HR.01.01.01, 01.02.01, 01.02.07

Assuring that proper infection control procedures are used in “sending” and “receiving” patients:
IC.01.01.01, 02.01.01, 02.02.01, 02.03.01

Assuring that organizational leadership promotes and provides resources for safe, quality transitions of care:
LD.02.03.01, 03.03.01, 03.04.01, 04.03.01

Assuring safe medication management for patients being transitioned from one provider to another:
MM.01.01.01, 03.01.05, 04.01.01, 05.01.01, 06.01.03
Home Care Standards Related to Transitions of Care (cont’d.)

Assures patient safety throughout every patient transition of care:
NPSG.01.01.01, 03.06.01, 09.02.01, 15.02.01

Assuring safe provision and coordination of care, treatment, and services:
PC.01.01.01, 01.02.01, 01.03.01, 02.01.05, 02.02.01, 02.03.01,
04.01.01, 04.01.03, 04.01.05, 04.02.01

Assures that all patient care information is documented in the patient record:
RC.02.01.01

Assures that the patient’s rights and responsibilities are communicated and respected throughout every transition of care:
RI.01.01.01, 01.01.03, 01.02.01, 02.01.01

Outcomes from the project:

1) Development of ToC portal
   - Research and information gathered in one place to share with customers and the public

2) Expert panel, focus group calls, and learning visits
   - Assisted us in developing publications and education for our customers, central office, and field staff
   - Feedback helped us to further evaluate current standards as they relate to ToC rather than write new standards

3) Development of new Integrated Care Certification (ICC) program

The Joint Commission
Integrated Care Certification Program

Integrated Care Certification (ICC):

- A new optional certification program that provides an evaluation of the integration of care across health care settings*
  (*currently for hospitals, physician practices and ambulatory settings)
Integrated Care Certification: Program Standards

> Emphasis of requirements:

- An organized integrated care program
- Interdisciplinary team leadership whose members support the coordination of clinical care

Integrated Care Certification: Program Standards (cont’d.)

> Emphasis of requirements:

- Leadership endorsement and support of the program’s goals for providing care, treatment, and services
- A special focus on patient and family engagement
- Processes that support the integration and coordination of patient care among health care settings and providers

Integrated Care Certification: Program Chapters (3)

**Program Alignment (ICPA) chapter:**

- The structure and organization of the program

**Program Characteristics (ICPC) chapter:**

- Involvement of the patient and/or family
- Managing transitions of care
Integrated Care Certification: Program Chapters (3) (cont’d)

Quality, Safety, and Culture (ICQS) chapter:

- Performance improvement priorities and activities

Integrated Care Certification: Next Steps

- Initial ICC program with focus on integration of care between hospitals and physician practice(s) networks or ambulatory care organizations – completed and approved
- Certification reviews started in 2015
- Jan. 2017: Expand program to evaluate the integration of care among hospitals, physicians, ambulatory clinics, and post acute settings, including Home Care and Nursing Care Centers (long term care)

Transitions of Care: Closing the Gap

Through these projects and activities, it is our goal to utilize the key concepts learned to assist our accredited organizations to develop successful methods for providing safe, quality care transitions
Improving the Quality of Care by Improving the Transitions of Care Process

Centers for Medicare & Medicaid Services
Hospital Discharge Planning Worksheet

Monitoring the Quality of your Organization’s Discharge Planning Process

Questions to ask:

- Are discharge planning policies and procedures applicable to all inpatients?
- Are staff following policy and procedure?
- Does the process have a method for early identification of patients at risk for problematic care transitions?
- Do staff, including physicians, know how to initiate discharge planning? Are patients aware they can request a discharge plan?
- Are discharge plans re-evaluated based on a change in patient condition?
- Is the discharge plan reviewed on an ongoing basis?
Questions to ask: (cont’d)

Are discharge planning staff competent and qualified?
Are discharge planning assessments documented and in the record?
Did the assessment include psychosocial factors?
Were the psychosocial factors considered in discharge planning?
Were the patient and family assessed in the ability to provide self-care/care?
Are community-based services offered based on assessed needs of the patient/family?

Questions to ask: (cont’d)

Did the patient choose the next provider or was the provider assigned? (home care, skilled nursing, etc…)
Was the discharge planning assessment initiated early in the admission?
Were assessments completed in a timely fashion?
Was the patient/family advised of assessment results?
Care options?
Did the discharge plan match the needs determined by the assessment and the interdisciplinary team?
Were the learning needs of the patient/family assessed and addressed?

Questions to ask: (cont’d)

Were written instructions provided to the patient/family in a manner that was clear to the patient/family?
Is there evidence of patient/family education in the medical record?
Is there evidence of referrals made?
Were arrangements made for DME, transportation, home care, follow up care?
Was necessary information sent to the next provider of care in a timely manner? (at time of transfer or before next appointment)
Questions to ask: (cont’d)

Are there delays in discharge due to failure to implement
the discharge processes?

Are final results of tests that were pending at time of
discharge sent to the patient and next provider of care?

CMS CoP §482.43 Discharge Planning

“Watch for the publication of the CMS Final
Rule and revised CoPs on discharge
planning (affects hospitals, critical access
hospitals, and home care)"

This would likely result in changes to the
CMS forms (Note: This may also result in
TJC standards changes)

For more information:

Transitions of Care Portal:
www.jointcommission.org/toc

Contact: Kathy Clark, MSN, RN
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“Evidence-based models of care are needed that promote greater cross-setting collaboration between health care professionals and also between health care professionals and patients along with their family caregivers.”

—Eric Coleman, MD