

Leveraging PSO Protections and Lean Six Sigma to Foster Quality and Safety Collaboration across Transitions of Care

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PROBLEM STATEMENT AND PROJECT GOALS

Bundled care payment models are challenging all healthcare providers to collaborate for higher quality, improved safety, and more efficient care across the spectrum. Partnerships between acute care and long term care (LTC) facilities are a critical component to this success.

To address this problem, our tertiary medical center formed a Post-Acute Preferred Provider Program, partnering with five LTC facilities in our region, with the aim of improving overall system performance for better health of the populations we share. Through this collaboration, a set of metrics was developed to examine efficiency of current processes in transitions of care, as well as quality and safety outcomes. Our goal was to find where the inefficiencies live and make improvements to support better system performance.

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Why use the PSO?

Our LTC partners were concerned about the potential for being singled-out as outliers or poor performers in any given metric. We leveraged the confidentiality protections offered by patient safety organizations (PSOs), assuring the facilities their individual outcomes would remain confidential, but also allowed for aggregate dissemination among the group. This creates an environment supportive of open sharing and problem solving.

Getting Started

Data was submitted monthly to the PSO, then aggregated and de-identified for presentation at our collaboration meetings. Baseline PSO data for the first 6 months helped inform the group and set priorities. Additionally, our LTC partners were provided a Lean Six Sigma (LSS) white belt class, outlining the DMAIC process (Define, Measure, Analyze, Improve, and Control) to promote shared language and understanding of improvement work. A portfolio of LSS projects were deployed to improve processes crucial to smooth transitions of care and advanced care planning. Initial areas of focus included:

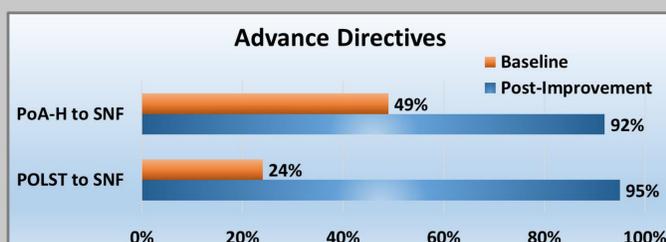
- **Advance Directives received by SNF**
- **Nurse-to-Nurse Handoff Report**
- **Controlled substance prescriptions received by SNF at discharge**
- **Optimizing Heart Failure Care**

Advance Directives

Process improvements included:

- SNF sending Advance Directives (AD) with all patients presenting to the ED
- AD sent from the hospital to SNF with all referrals
- Updated EMR alerts/documentation to trigger both

Statistically significant improvements were recognized for the exchange rates for Power of Attorney for Healthcare (PoA-H) documents by 43% and Physician Order for Life Sustaining Treatment (POLST) by 71%, shown in the graph below.



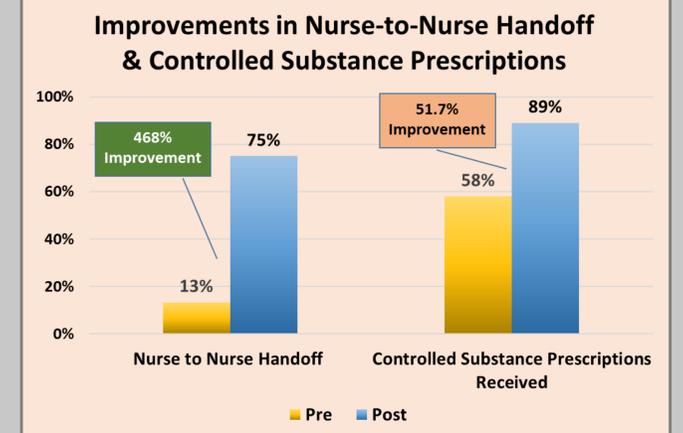
Nurse-to-Nurse Handoffs and Controlled Substance Prescriptions

Separate baseline data collection (non-PSO data) showed that nurse-to-nurse handoffs were only occurring 13.3% of the time; and LTC facilities were only receiving written controlled substance prescriptions 58% of the time.

Identified gaps in both the Nurse-to-Nurse Handoff and Controlled Substance projects included no standardized place for documentation and lack of awareness by the clinicians of what is required.

For the Controlled Substance project, improvements included a standardized location for documentation, as well as alerts built into the EHR notifying clinical staff what medications were needed at discharge and identifying whether they were a controlled substance. This accounted for a 51.7% improvement in written controlled substance prescriptions received by the LTC facility, shown in the graph to the right.

For the Nurse-to-Nurse Handoff project, improvements included communication of the need for handoff prior to discharge to an extended care facility, and a standardized location for documentation to occur. These changes accounted for a 468% improvement in documented handoffs.



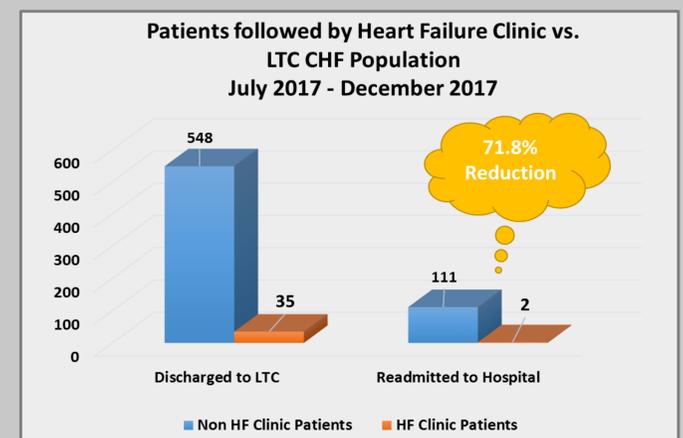
Optimizing Heart Failure Care

A clinical project targeting the optimization of heart failure patients in the LTC setting was also addressed. Gaps included a lack of trigger for accurate identification of CHF diagnoses upon arrival to the facility, lack of a standardized care plan, and lack of monitoring patients with CHF. Goals for this project included reducing presentations to the ED and readmissions to the hospital after discharge.

Improvements:

- Standardized discharge instruction and monitoring plan
- Establishing the patient with the Heart Failure Clinic prior to discharge
- Follow-up visits within 7 days of discharge
- Patient monitoring via telehealth equipment

Readmission rates decreased by 71.8% for patients who were followed by the Heart Failure clinic vs. the population of patients with CHF who were not followed, shown in the graph below.



Implementation Considerations and Lessons Learned

- Maintaining engagement with LTC stakeholders is critical. Hospitals often lack insight on the incredible amount of regulatory pressure LTC facilities are under – more so than acute care. Scheduling time for project team meetings and collaboration meetings has to be flexible and meet all parties needs.
- Leave blame by the wayside – focus on improving the process together through regular communication and supporting each organization's requirements.
- Mistakes and barriers need to be viewed as learning opportunities. Maintaining an open dialogue when patient transitions do not go smoothly is crucial to building trust and understanding.