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Improved Patient Handoffs Require Comprehensive Approach

Hospitals are paying more attention to patient handoffs as a crucial element in quality and patient safety, with an evolution toward seeing them as not just a distinct task, but more as a comprehensive strategy.

The importance of good patient handoffs has been recognized for years, but healthcare professionals now are looking beyond the primary handoff scenarios such as shift changes and moving a patient from one hospital department to another, says **Faye Sullivan**, RN, healthcare coach for the Studer Group, a consulting group based in Pensacola, FL.

Good handoffs still are vitally important in those situations, of course, but quality leaders also are looking to improve handoffs in other ways.

"The idea of a handoff and what that means has grown recently so that people are now looking at the 30 days after the acute care event in the hospital," Sullivan says. "They are looking at some of the strategies they may have employed in the past, like the post-visit phone call or interdisciplinary rounds, through a new lens and retool those to drive different outcomes from the same strategies."

> "HOSPITALS ARE NOW INCLUDING THE DISCHARGE AND AFTERCARE PROCESS AS A PATIENT HANDOFF."

Hospitals are including the discharge and aftercare process as a patient handoff, Sullivan says, with many using data analytics to determine which patients are most likely to return to the hospital and why, and then formulating a series of post-visit phone calls to address those risks.

"If you go home from the hospital after an appendectomy, we'll call you at day two or three to make sure you're progressing as expected, but if

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you go home with congestive heart failure we'll call you at day twoor three, but we'll also call you at day seven," Sullivan says. "That's because we know that around day nine or 10 we often see congestive heart failure patients back the hospital because they've not followed through on home care instructions. If we call you back at day seven to find out if you've filled your prescriptions and whether you're gaining weight, we're much more likely to avert readmissions."

Catch Patients in Time

Those patients also receive a call after three weeks because data indicate that they often return to the hospital at about four weeks. Patients leave the hospital "scared straight" about their condition and determined to do what is necessary to maintain their health, but that conviction wanes over time and their health begins to fail, Sullivan says.

"If we call them at day 21 and ask them to compare the first week after discharge to how they are managing their healthcare now, we can look for slippage and get people back on the right track so they avoid that day 21 to day 30 readmission," Sullivan says. "The concept is not new, but it's been retooled in light of the data showing what we need to pay attention to."

That approach also plays into another facet of patient handoffs getting more attention: the patient's engagement in his or her own healthcare. Hospitals are working to meet patients where they are in terms of understanding, motivation, and ability to care for themselves.

"If I'm a patient who is highly engaged in managing my own health, I may not need that 21-day phone call because I'm less likely to fall off a cliff," Sullivan says. "But if I am a newly diagnosed patient or a patient who has been admitted many times in the past and you know I'm not engaged in managing my care, that will drive not only the frequency of contact but the style of contact you have with them."

For instance, with patients who are less engaged in their own care, Sullivan encourages healthcare professionals to provide little bits of information more often. Giving them too much information at once overwhelms them and can further disengage them, she says.

'Handovers' Conveys Right Message

Sullivan and her colleagues also urge healthcare providers to change the terminology from patient handoffs to patient handovers. They think the word "handoff" sounds like clinicians are offloading patients and the clinician stops caring, whereas the word "handovers" conveys that one caregiver is transitioning care to another caregiver in a meaningful and thoughtful way.

"'Handoff' implies that I'm handing you to someone else and I'm washing my hands of you, I'm done," she says. "A 'handover' implies more of a continuum of care. I'm still invested in you and I'm still a member of your care team. Just because you're not in the bed in front of me doesn't mean I no longer care for you or have any responsibility for you."

That distinction is more than just symbolic, Sullivan says.

Healthcare professionals must be encouraged to think of themselves as still involved in a patient's continuum of care even if the patient is not physically under their care now, she says. The patient may have been transferred to another department or another professional's care, but the professional making the handoff must still be ready to participate by providing needed information or other support, she says. *(See the story in this issue for one hospital's take on patient handoffs.)*

"The days of looking at the doors to your unit and thinking you're off the hook once they pass through those doors are over," Sullivan says. "It's not about who has custody of the patient now. It's about the organization and everyone involved taking responsibility for the whole continuum of care."

Combine Multiple Strategies

The best strategies for improving patient handoffs take a more comprehensive approach instead of focusing exclusively on that moment when a patient's care is transferred from one caregiver to another, says **Christopher Landrigan**, MD, MPH, pediatric hospitalist at Boston Children's Hospital and associate professor of pediatrics and medicine at Harvard Medical School. Landrigan also is founder and a board member of the I-PASS Patient Safety Institute, which promotes safe patient handoffs, and principal investigator with the I-PASS Study Group.

I-PASS is a mnemonic used to ensure caregivers address the key elements of a good handoff: Illness severity, Patient summary, Action list, Situation awareness and contingency planning, Synthesis by receiver. *(See the story on in this issue for other tips on what to cover in a patient handoff.)*

He notes that the I-PASS program originated with efforts to reduce resident work hours, which resulted in more patient handoffs. As Landrigan and colleagues looked at how to make those handoffs safer, they realized that other successful quality improvement efforts took a broad approach.

"When you look at reducing hospital-acquired infections, the most successful interventions were not just focusing on handwashing as the sole thing you should do, but rather a whole series of complementary interventions that resulted in reducing infections," Landrigan says. "They optimized handwashing efforts with improved use of sterile precautions, prepping the site well, avoiding the femoral site — a whole series of little steps that, in the aggregate, drove hospital-acquired infections down by about 80%."

Landrigan and his colleagues took the same approach with patient handoffs, not focusing on just a computerized handoff tool or teamwork training, but

Hospital Improves Handoffs with Walkabouts, Patient Education

A California hospital is using a walk-around, patient education, and a "ticket to ride" to ensure safe patient handoffs.

The effort is aimed at ensuring good communication among all participants, including the patient and family members, says **Gemma Seidl**, RN, MSN, MPH, PHN, executive director of critical care, telemetry, and renal services at St. Joseph Hospital of Orange.

During shift change, registered nurses and nursing assistants perform a walk-around in which the outgoing staff introduces the incoming staff to the patient and family. They also inform the patient that they are handing off the care, and use a template to review key items such as medication.

When transporting patients to procedural areas, for both monitored and non-monitored patients, the RN in charge of the patient completes a "ticket to ride" documentation in the electronic medical record, prints the form, and hands it to the receiving procedural RN or transporter.

Upon the patient's return to the unit, the transport RN or transporter will hand the ticket to ride back to the nurse with a handoff signature. The receiving RN signs the form to acknowledge arrival and acceptance of the patient. ■

SOURCE

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bundling those strategies with others for a comprehensive way to improve handoffs. They developed a training program, an improved verbal process with the I-PASS mnemonic, and a handoff tool that reinforces best practices.

Is It a Priority?

A hospital quality professional seeking to improve patient handoffs must first determine whether it is a priority for the organization. Though good handoffs should be the goal of all healthcare professionals, an organization may not be able to prioritize it now, and that will stymie any improvement effort, Landrigan says.

"This requires a substantial amount of support and input from the highest levels. This is a culture change," Landrigan says. "You're asking people to speak differently, and that requires a lot of time and effort to make it happen day in and day out for every patient every time. It's one thing to train people, but it's another thing entirely to get people to actually change what they do daily."

A common occurrence is to provide training, maybe even change the electronic medical record to encourage proper handoffs, but two months later no one is doing what you taught them, he says.

Integrate Across Service Lines

Integration of services also is a key component of good patient handoffs, says **Rohit Uppal**, MD, SFHM, president of Acute Hospital Medicine, TeamHealth, a company in Knoxville, TN, that provides physician staffing and support services.

"We spend a lot of time talking about patient handoffs within a service line, how to hand off a patient from one doctor to the next. Less attention has been paid to how all the departments and service lines are coordinating their efforts for the good of the patient," he says. "As patients come through the emergency room and need to be admitted to the hospital, we work to ensure good communication through that continuum as soon as possible. That means good communication around clinical issues and coordination of care."

For instance, the company encourages parallel processes rather than waiting for one physician to complete care before the next begins. One challenge is that in many hospitals, communication lines between services is asynchronous, Uppal says.

"People are depending a lot on documentation and reading each other's notes. If you can design workflow so that you have more verbal interactions, you can have people asking questions more freely and cut through a lot of the inefficiencies in the EMR, with information not being transmitted effectively," he says. "As you have people from different service lines interacting more, they start to understand each other's challenges and they find ways to make the transitions smoother and better for the patient."

Tips for Improving Patient Handoffs

Lack of communication is the single most common root cause factor that leads to liability claims, and those claims often involve patient handoffs, according to The Doctors Company, a medical liability insurer in Napa, CA.

Appropriate communication among physicians, nurses, and all other members of the healthcare team is essential in preserving continuity of care for the patient, so The Doctors Company offers the following tips for improving communication during handoffs:

- Allow interactive communication for questions or discussion, and require repeat-back of the exchanged information.
- At a minimum, include these information items in handoffs: diagnoses, current condition, recent changes in condition or treatment, anticipated changes, and warning signs of changes in the patient's condition.
- Limit interruptions during handoffs.
- Use the following questions for guidance in organizing communication during the handoff:
  - What is important to communicate?
  - Who needs to know what information?
  - When should communication occur?
  - How should the information be transmitted?
  - How can I validate the communication was successful? ■

Workflows tend to be well ingrained in service lines, so expect some resistance, Uppal says. Technology also can pose roadblocks, as well as the lack of resources needed to make any change.

"You have to spend a lot of time building the 'why' behind it, because it won't be hard for people to come up with reasons to stick with the way it's always been done," he says. "It's easy for providers to be blind to the negative impact of that lack of coordination and communication. Having leaders who can shine light on the errors, inefficiencies, and quality problems that are occurring can drive clinicians to be more open to change in their workflow."

Don't Drop the Ball

A football analogy can help explain handoffs with some clinicians, says **Dennis Deruelle**, MD, FHM, national medical director for acute services with IPC Healthcare/TeamHealth, a company providing healthcare professional staff and integrated care providers in Tampa, FL. Think of the patient as the football.

"In a football game, the football is all important and you never want to fumble it, drop it. People are very careful to take care of it, and in healthcare you have one person handing it another, with one person as the giver and another at the receiver," Deruelle says. "If either one of them isn't paying attention or doesn't do everything necessary to take care of that football, you have a fumble. When that happens, it's bad and that's where errors happen."

It also is important to get patients involved in good handoffs, Deruelle says. They often have no idea how many times they are handed off from one caregiver to another.

"Patients need to be aware of when they are being handed off, such as with shift changes, and they need to understand the importance of a good handoff. If they think the handoff hasn't gone well, they need to pick up that fumble and protect themselves," Deruelle says. "This requires education and encouraging patients to speak up when they hear the doctor tell someone he's going home that day, when the patient knows he's not. The patient has to know when a handoff has occurred, and when it doesn't occur in the right way they have to fill in the gap." ■

SOURCES

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Staffing Grid Improves Satisfaction for Patients and Nurses, Reduces Falls

A new staffing grid focused on improving patient, nurse and staff satisfaction contributed to reducing patient falls by 50% and staff injuries by 81% over approximately one year at Sharp Memorial Hospital in San Diego.

The initiative also increased staff's perception of adequate staffing 43%, and the combined outcomes resulted in an estimated annual fiscal impact of $1,086,147.

The project was spearheaded by **Boni Bogart**, BSN, RN, PCCN, and **Julie Tarbell**, BSN, RN, both charge nurses and clinical leads on one of four specialty progressive care units (PCUs) at the hospital, this one specializing in medical cardiopulmonary patients. The 32-bed unit has 17 progressive care certified nurses (PCCNs).

Bogart says night nurses on the unit often expressed concern about staffing, particularly their perception that there was not enough ancillary support. They typically had only two aides, and sometimes only one, to share among up to 12 nurses on the night shift, she says.

"As a progressive care unit, we have high acuity patients and we must do a lot of critical thinking, so without the ancillary support, our nurses were being torn between doing primary care and going through all the critical thinking that was necessary for the patient

to receive the best care," she says. "So, we sat down and talked with the frontline staff to ask what they thought would make them feel comfortable taking care of their patients, and the consistent answer was that they thought they didn't have enough ancillary support. They felt like they were constantly toileting and running to call lights, which took them away from critical tasks like medication and doing discharge education."

Bogart and Tarbell looked at moving the PCU to more of a team approach to nursing and redesigning the nursing grid, seeking ratio of one aide to two or three nurses. In formalizing the project, they established specific goals: increase patient perception of staff responsiveness to needs by a 10th percentile on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), decrease patient falls 5%, increase staff satisfaction, increase perception of adequate staffing by 10% on a staff survey, and decrease employee injuries by 5%.

Nurses Given a Voice

There was initial resistance and skepticism, Bogart says, but that was overcome by giving the nurses a voice in what happened.

"Bringing it from the frontline staff, showing them that this something that came from the frontline and wasn't handed down by management, was key," Bogart says. "We tried to keep that up at every step along the way, getting their input at different points and keeping this as a project driven by the nurses and not something that administration was telling us to do."

The project started in January 2016. The key challenges they faced include the inclusion of float and travel staff, getting buy-in from the naysayers, training and retraining novice healthcare assistants (HCAs), peer-to-peer accountability of expected roles, delegation, and aligning the new staffing grid with productivity targets. They also faced unit flooring construction that had half of the unit shut down for approximately a month, along with excessive floating of unit staff and unexpected prolonged union negotiations.

The different staffing ratios between day shift and night shift contributed to staff dissatisfaction, Tarbell says. The new staffing grid they designed changed the ratios to provide more ancillary staff.

"Our staffing ratio on the day shift was three patients to one nurse, and night shift had always been four-to-one. We were asking the staff on day shift to go to four-to-one, so we would have fewer RNs on the floor but could accommodate more ancillary staff," Tarbell says.

The night shift was happy with that because they got more ancillary staff and were already at four-to-one. The day shift had to be convinced that going to four-to-one was going to be beneficial to everyone.

"They already felt like they were barely keeping their heads above water with the three-to-one ratio, and now we were asking them to take on another patient. On the surface, it didn't look like we were doing them any favors, but we had to show them that with the additional ancillary staff they could benefit from the new grid," Tarbell says. "It took some time to convince them that by working as a team with another nurse and an aide, they were going to have more time to take care of their patients safely and effectively because they have the help."

Culture Change Took Finesse

Bogart notes that even though the hospital was responding to their concerns about staffing, some nurses found it difficult to accept the new arrangement.

"We created the new grid, but then we had to talk about what this was going to look like on the floor,

because this was going to be a huge culture change for us. Our nurses are used to being primary care and sometimes not using the ancillary staff on the unit during their shifts because the aides were tied up with the other 11 nurses," Bogart says. "They had wanted more help, but at the same time they had to learn to delegate because they were so used to doing everything themselves when they didn't have the help."

Tarbell says she and Bogart had assumed that the nurses knew how to delegate, but that proved not to be the case and they had to help the nurses learn delegation skills. The use of float and travel nurses also proved problematic, necessitating a training session at the beginning of the shift to show them how the unit operated and used the HCAs.

"Once this was all set we had a two-hour mandatory meeting for staff to show them how this worked, but the float and travel staff didn't get that training, so we had to do it each time a new person arrived for a shift," Tarbell says.

Workflow Analysis Helped

In devising the new staffing grid and ratios, Bogart and Tarbell conducted a workflow analysis for each staffing role in the PCU, asking nurses to describe what they typically did on their shifts from moment to moment. That helped them show the nurses how they could better allocate their time if they had ancillary staff who could take on some those time-consuming tasks, but it had limitations.

"We were breaking down their days to show them the different things that took them away from the patient care they really needed to be doing, but we also learned that that was something subject to constant change. We couldn't say we were going to provide the perfect day, because everything changes from one day to the next," Bogart says. "We were trying to say you're going to have more good days than bad days under this system, and that's realistic. It was hard at some points because we were trying to find a perfect solution and we kind of took it personally when we realized we couldn't, but then we focused on the idea of making things so much better than they were before."

New healthcare aides were hired for the new staffing grids, with the assumption that they were trained and ready to go, but the PCU nurses soon found out that they were not. That set the effort back a while as the new HCAs were trained, or retrained, for their duties.

HCAs now do more than they did before this initiative, such as taking vital signs. Individual aides always stick to a smaller area on the unit, with the two or three nurses on their teams, rather than moving up and down the unit's hallways, which happen to be particularly long. That means each HCA can achieve more during a shift because he or she is travelling less, Bogart says.

Improved HCAHPS, Fewer Infections

They used a workflow model survey with both registered nurses and HCAs, administered pre-implementation of the project and during the last month of data collection. The four-question survey assessed staff's perception of staffing and allocation of resources.

Improving staff satisfaction and perception were only part of the project, Bogart and Tarbell say, because they knew that happier employees work better. That translates directly into better-quality care and outcomes, they say.

In addition to the positive effects on falls, injuries, and staff perceptions, Bogart and Tarbell say the project generated positive feedback from float staff, with some asking to work on the unit, and HCAs feel more empowered. There have been zero catheter-associated urinary tract infections (CAUTIs) since the project rollout, and a significant reduction in hospital-acquired *Clostridium difficile* infections.

The overall results for HCAHPS (top box) increased six percentile points, and nurse communication increased 14 percentile points.

Listen to Staff Feedback

The project succeeded in part because Bogart and Tarbell listened to feedback from the staff and took their opinions into consideration when devising changes and tweaking plans as they unfolded, Tarbell says.

"If you want to implement something like this, you must be visible on the floor and listen to what people say," Tarbell says. "That was instrumental in making that culture change for us."

Bogart agrees and advises not expecting unanimous approval for every step along the way, even when trying to respect the opinions of staff members.

"In the beginning, we were

afraid of not making everyone happy all at once. We had all these great ideas that were coming from the frontline staff, but obviously not 100% of everyone is going to be in favor of every change," Bogart says. "But we finally found a workflow that adjusted everything in a positive direction, even if it's not perfect. It's taken a long time, but even the naysayers seem happy now and we don't disregardthe death look as nurses came on shift because they thought they might have to take on a fourth patient. You just have to know that you won't make everyone happy all the time, but you can still move forward."

Support Creative Staffing Solutions

Bogart and Tarbell created the quality improvement project as part of the American Association of Critical-Care Nurses (AACN) Clinical Scene Investigator Academy. AACN practice excellence director **Devin Bowers**, MSN, RN, NE-BC, in Aliso Viejo, CA, says it illustrates common findings in many quality initiatives.

"It's important to get staffing right. Inappropriate staffing can have devastating consequences to our patients' safety and nurses' well-being. Solving nurse staffing challenges requires creativity and commitment at all levels," she says. "There is no simple one-size-fits-all solution or fixed ratio that can address the complexities involved with appropriate staffing, especially in acute and critical care."

Staffing is a complex process with the goal of matching the needs of patients and their families with the competencies of nurses and other members of the interprofessional team, she says.

The CSI participants at Sharp Memorial took on the challenge and developed a staffing solution that worked for their unit's patients, nurses and care team, with measurable clinical and fiscal improvements, he says. Supporting this type of nurse-led innovative thinking is one approach hospitals might consider in addressing staffing issues, she says.

"By empowering staff nurses — those at the frontline of patient care — to initiate change and improve everyday processes, hospitals can find creative solutions to diverse healthcare challenges," Bowers says. ■

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Copy-and-Paste Continues to Threaten Documentation Safety

Copy-and-paste is so easy and time saving that it can be tempting to overuse it in the medical record, and some electronic medical records encourage clinicians to use blocks of text over and over. Liberal use of copy-and-paste can diminish the quality and reliability of an electronic medical record, however.

Some medical records even routinely repeat blocks of text from previous versions of the note, without the user manually doing so.

Copied information in a medical record can mislead clinicians in several ways, says **Diana Warner**, MS, RHIA, CHPS, FAHIMA, director of health information practice excellence with the American Health Information Management Association (AHIMA) in Chicago. For instance, information that was accurate when first entered may no longer be accurate, but is copied forward into the current version of the note.

Copying too much information also promotes "note bloat," in which the record becomes so large that it is difficult to find what you're looking for, Warner says. "You also can have redundant information that makes it difficult to seewhat is new in the record. If you see the same thing over and over, it can make it hard to see what is new and notice any noteworthy additions, to know what's going on with the patient right now," she says. "There also is the danger of copying and carrying forward incorrect information, or maybe you didn't copy the full text that you needed. Maybe the patient has a family history of breast cancer, but you only copied history of breast cancer, and now that is going to totally change how you look at

and treat that patient."

The legal veracity of the note can be compromised, and overcopying can result in both undercoding and overcoding, Warner says.

The risks posed by overuse of copy-and-paste were illustrated in a recent study led by **Michael D. Wang**, MD, a physician in the Department of Medicine at the University of California, San Francisco (UCSF). *(An abstract of the report is available online at: http://bit.ly/2wqepeJ.)* While previous studies on copied text could not distinguish manually modified text from automatically updated, imported values in electronic note templates, Wang's study used a new tool that distinguishes manual, imported, and copied text in hospital progress notes.

Wang and his colleagues studied records from an inpatient electronic record at the UCSF Medical Center. They analyzed 23,630 inpatient progress notes written by 460 clinicians, including direct care hospitalists, residents, and medical students on a general medicine service over an eight-month period.

They found that 18% of the text was manually entered, 46% copied, and 36% imported. Residents manually entered less (11.8% of the text) and copied more (51.4%) than did medical students (16.2% of the text manually entered and 49.0% copied) or direct care hospitalists (14.1% of the text manually entered and 47.9% copied).

With less than one-fifth of note content manually entered, Wang says the results cast doubt on the validity of many electronic records.

"A better system is like the tool we used that lets you see what was imported from the previous version or a template, and what was manually entered that day. Those manual entries are usually what you're looking for," he says. "That separation of the pure clinical note from the other functions of the electronic record, like billing or clinical history, are key to ensuring the validity of the text that clinicians are depending on."

Wang and his colleagues suggest in the paper that more electronic records could be designed so that copied and imported information is readily visible to clinicians as they are writing a note, but not stored as a permanent part of the note.

> "THE LEGAL VERACITY OF THE NOTE CAN BE COMPROMISED, AND OVERCOPYING CAN RESULT IN BOTH UNDERCODING AND OVERCODING."

In the meantime, Wang suggests educating clinicians about the risks and, particularly, the dangers of depending too much on a copied clinical history.

"They will rely on that clinical history, but is that really the medical record really the best place for that clinical history to live? Maybe it should live somewhere else so the clinical history is not compromised and isn't overwhelming the part of the record the provider wants to access," Wang says. "But that's something we have to work on with our vendors."

Wang's research also revealed a belief among some clinicians that more text leads to higher billing, which he says should be addressed with education on why that is not so.

When medical records are compromised by overuse of copying, so is patient safety, Warner says.

"Simply making the record too long and full of too much text is a danger. When you have providers wading through so much text, especially blocks of repeated text, they may not have the time to go through all of that and pick out what one bit of information is key for the patient's care at that moment," she says. "Particularly in an emergency situation, the provider may look at all that text and decide there's no time for that. They will act on what they normally do in this situation without that information available."

Hospitals should address the risk through policies and workflow analysis, Warner says. Identify when clinicians are using copy-and-paste and why, then educate them about the potential dangers. Implement policies that specify when it is allowed when it is not, she suggests. *(AHIMA offers guidelines on copy-and-paste use at: http://bit.ly/2eqwwsC.)*

"There may be alternatives that could be offered, such as using scribes to capture information during a patient encounter, and systems that use voice recognition," she says. "There are times when it is okay to copy information and bring it forward, such as a past surgical history or similar information that has not changed since the last visit." ■

SOURCES

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Hartford Healthcare Launching Quality Initiatives

Hartford HealthCare, a healthcare network in Connecticut, is launching a series of quality initiatives aimed at getting patients the care they need quickly and safely.

Over the next seven years, Hartford HealthCare will work together with GE Healthcare, a consulting company, to help patients avoid unnecessary wait times and "traffic jams" that can delay care.

The projects will rely on advanced analytics to determine the best strategies for clinical program and capacity design, and Hartford HealthCare's new Care Logistics Center. The center's goal is to improve patient and staff experience by reducing waiting times and improving communication between providers and facilities.

Hartford Healthcare has four goals with the projects:

- Enhance the patient experience through more efficient access to diagnosis, testing, and treatment.
- Leverage advanced analytics to support ongoing operational and clinical improvements that could lead to faster care.
- Drive improved efficiency to lower the cost of care and provide more than $14 million in savings over the seven-year course of the relationship.
- Further develop complex digital imaging services, with improved staffing models and better technology to enable more efficient access for patients across the system.

Over the course of the seven-year project, both organizations have committed to achieving measurable improvements and outcomes.

Imaging services will be a key focus of the effort, says **Rocco Orlando** III, MD, senior vice president and chief medical officer for Hartford HealthCare. Imaging plays an increasingly important role in medical care, he notes, but it can be problematic in terms of maintaining a smooth flow of patients and controlling costs.

DATA ON PATIENT VOLUME AND FLOW ARE PLUGGED INTO THOSE MODELS, AND DIFFERENT STRATEGIES CAN BE APPLIED TO SEE WHAT EFFECT THEY HAVE.

"Imaging is a complicated, diverse, and increasingly complicated business, so we wanted to look at how we operate our imaging services and looking for improving efficiencies," he says. "We also wanted to look long-term at what we need in terms of technology, what's needed, and what locations to best serve our patients. We know that wait times for imaging services, particularly for diagnostic services when someone is anxiously awaiting a diagnosis, is important and we want to improve our service in that area."

Patient flow and the logistics of moving patients around is a key concern, Orlando says.

"Our flagship academic medical center, Hartford Hospital, is bursting at the seams, so we struggle at times with emergency department wait times, patients that are boarding, flow through our units. But we have community hospitals where they may not have all the beds full," he says. "So, we want to really step back and see how we can most effectively manage these assets for the system rather than looking at just one hospital at a time. We want to be able to manage the flow of our assets from institution to institution so that we can serve our patients most in the best way."

Part of the effort will involve creating a "digital twin" of the hospitals, explains **Dominic Foscato**, principal of GE Healthcare Partners. Data on patient volume and flow are plugged into those models, and different strategies can be applied to see what effect they have.

"After a few months of looking at those different options, testing one idea and then another to see how they affect the way patients are moved through the system, we can select the strategies that have worked in the digital model, the specific ones in which we have high confidence for addressing the challenges faced by the hospitals, and apply them in the actual facilities," he says. ■

Secondary Heart Failure Affects Readmissions

Heart failure that develops or worsens during a hospital stay can affect outcomes, costs, and readmissions, so hospitals are advised to identify patients at risk for secondary heart failure.

Heart failure is the leading cause of hospital admissions and readmissions in patients older than 65 years, and is a leading cause of death among hospitalized patients, notes **Vlad Gheorghiu**, MSN, NP, AGACNP-BC, PCCN-CMC, a graduate student in the Adult-Gerontology Acute Care Nurse Practitioner Program at the School of Nursing at California State University (CSU), Los Angeles. However, patients who are admitted for a different reason may develop secondary heart failure while they're in the hospital, complicating their recovery.

Gheorghiu's recent research explores possible strategies by which nurses and clinicians can identify secondary heart failure in hospitalized patients and implement early measures to prevent progression to acute decompensated heart failure. He worked with program coordinator **Thomas W. Barkley Jr.**, PhD, ACNP-BC, director of nurse practitioner programs at CSU, for the research. *(The article is available online for a fee at: http://bit.ly/2vvtmii.)*

Addressing this risk begins at admission but should continue after discharge, he says. Patients can quickly progress to acute decompensated heart failure if early signs and symptoms of heart failure are not identified in a timely manner.

Early discovery and intervention are important, but it should be reinforced along the continuum of care, including after discharge, Gheorghiu says. Reimbursement pressures related to readmissions and outcomes should be another motivation for hospitals to address this risk, he says.

"The restrictions they're putting on payment and reimbursement are based on outcomes, so it is very important for hospitals and healthcare systems to take measures that prevent complications or lead to longer hospital stays," he says. "It's important to come up with a system that engages patients and providers. The hospitals that have addressed this effectively engaged a wide range of people, including dieticians, pharmacists, case managers — all the people who can provide the necessary elements to make sure the patient is safely discharged home."

Heart failure management should include stratifying risk based on factors such as age, heart rate, blood pressure, diabetes, and existing cardiovascular conditions, he says. An effective program also will focus on recognizing early signs and symptoms, identifying differences between heart failure and conditions with similar symptoms, and correlating assessment results with laboratory data.

Gheorghiu also recommends that a patient's plan of care incorporate guideline-directed medical therapy, management of comorbid conditions and precipitating risk factors, health promotion, and self-care education. At the organizational level, hospital-established protocols should identify and assess patients with potential and existing heart failure, he says, and comprehensive education programs for nurses and other clinicians may also improve outcomes for high-risk patients.

At the hospital where he previously worked, Gheorghiu says, clinicians routinely identified patients with active heart failure and those at risk for heart failure, regardless of their cause for admission.

"Based on that list, we would implement a bundle or protocol of things we had to do with that patient each day or that had to be done prior to that patient's discharge," he says. "For example, we would work with the dietician to provide an appropriate diet when the patient went home, and we would work the pharmacist to provide education on heart failure medication and how take them. We reinforced symptoms to watch out for at home that could indicate heart failure is worsening, and how to keep track of their weight daily, all to catch symptoms early and keep patients from decompensating."

Gheorghiu says his research found few hospitals utilizing such a protocol specifically to identify and manage patients with secondary heart failure. ■

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CE QUESTIONS

1. What does Faye Sullivan, RN, suggest is a better term than "patient handoff?"

a. Patient handover
b. Patient transfer
c. Patient exchange
d. Patient progression

2. In the quality improvement project at Sharp Memorial Hospital in San Diego regarding staffing, how much were employee injuries reduced?

a. 21%
b. 41%
c. 61%
d. 81%

3. In the study on text in electronic medical records led by Michael D. Wang, MD, what percentage of the text was manually entered?

a. 8%
b. 18%
c. 38%
d. 58%

4. What is one suggestion from Wang for how to improve the quality of electronic medical records?

a. Prohibit physicians from using copy-and-paste.
b. Prohibit software that automatically copies some text blocks.
c. Design electronic records so that copied and imported information is readily visible.
d. Require permission from supervisors before text can be copied and pasted.

CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.