“Safe Passage”
A Virtual Nurse to Nurse Transition of Care

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Background

Communication problems caused almost 70% of sentinel events and at least 50% of the breakdowns took place during handoffs.

Up to 76% of re-hospitalizations occurring within 30 days in the Medicare population are potentially avoidable.

Nearly one-fourth of Medicare beneficiaries discharged from the hospital to a SNF are readmitted to the hospital within 30 days, costing Medicare $4.34 billion annually.

Inadequate management of care transitions was responsible for $25 - $45 billion in 2011 through avoidable complications and unnecessary hospital readmissions.

Poorly executed care transitions negatively affect patients' health, well-being, and family resources as well as unnecessarily increase health care system costs.
Connect to Purpose: Abe’s Story
There is another way...

Phone calls and large packets of information are not enough to ensure a safe patient transition outside the walls of the hospital.
Benefits of a Virtual Transition of Care:

Patient Centered Communication
- Opportunity to clarify the patient’s goals of care
- Expectations for the next level are reviewed, assists with alleviating fears

Teammate Engagement
- Working as “One” to ensure a safe patient transition from one level of care to the next

Improves Safety
- Important information is shared around medications, wounds, special care needs
- Receiving nurse can view, hear, and talk to the patient/family

Time Efficient
- Decreases need for additional phone calls
- Immediate care needs are clear

Cost Savings
- Decrease readmissions and ED visits
- Low cost intervention
Pilot Project:

- Stakeholder Engagement
- Process Mapping
- Standardized Script
- Mock Handoff Events
- Realtime Feedback
- Measures of Success

Project A3
Training Video:

http://peopleconnectmore.carolinas.org/media/flowplayer/index.cfm?sitename=Synapse&fName=Virtual-Nursing-Handoff
Measures of Success:

Decrease < 30 Day Readmissions: Premier Data (Quantitative)
- Total # of patients admitted to Jesse Helms Nursing Center from CHS Union with and without the virtual handoff and subsequent readmission rates
- Total # of H@H patients readmitted in <30 days with and without the virtual handoff

Improve Transition Safety: Agency for Healthcare Quality and Research (AHRQ) Nursing Home Survey (Qualitative)
- Comparison between the Jesse Helms Nursing Center response to the 2015 vs. 2017 SNF AHRQ Nursing Home Survey questions related to handoffs

Improve Patient Satisfaction and Acceptance of Home Health Services: Virtual Handoff Survey (Qualitative)
- Total # of refusals of admissions to H@H with and without the virtual handoff
- % Yes response to the question “Do you feel the virtual handoff was a positive experience?”
## Results:

### Safe Passage CHS Union to Jesse Helms Readmissions Comparison

**July 2016 – December 2017**

<table>
<thead>
<tr>
<th>Jesse Helms Nursing Center</th>
<th># of SNF Admissions from CHS Union</th>
<th># of Observed Readmissions</th>
<th>Readmission Rate</th>
<th>% Difference in Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Without Virtual Handoff</td>
<td>271</td>
<td>26</td>
<td>9.6%</td>
<td></td>
</tr>
<tr>
<td>Total # With Virtual Handoff</td>
<td>153</td>
<td>10</td>
<td>6.5%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>424</td>
<td>36</td>
<td>8.5%</td>
<td></td>
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</tbody>
</table>

### Safe Passage to Healthy@Home

**April 2017 – December 2017**

- Total of 51 Virtual Handoffs to H@H
- (3) patients who were transitioned virtually were readmitted in <30 days
- 3 Readmissions/51 Virtual Handoffs

**5.9% Readmission Rate**
Results:

Jesse Helms Nursing Center AHRQ Survey Comparison
Handoff Domain

- Staff are told what they need to know before taking care of a resident the first time:
  - 2015: 62%
  - 2017: 72%

- We have all the information we need when residents are transferred from the hospital:
  - 2015: 57%
  - 2017: 61%

- Staff are given all the information they need to care for residents:
  - 2015: 68%
  - 2017: 74%

Safe Passage Acceptance Rate to Healthy@Home
April 2017 – December 2017

<table>
<thead>
<tr>
<th>Healthy@Home</th>
<th># of H@H Admissions</th>
<th># of Refusals</th>
<th>Acceptance Rate</th>
<th>Virtual Handoff Acceptance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Without Virtual Handoff</td>
<td>2762</td>
<td>775</td>
<td>72.0%</td>
<td></td>
</tr>
<tr>
<td>Total # With Virtual Handoff</td>
<td>51</td>
<td>0</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>2813</td>
<td>775</td>
<td>72.5%</td>
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Lessons Learned:

**WORK FLOW:** Understanding the current nursing work flow around the transition of care is necessary for embedding Safe Passage as a new process.

**SCRIPTING:** It is important that both the sending and receiving nurse use a script.

**SCHEDULING:** All must agree on a scheduling process for accountability.

**ENGAGEMENT:** If both the sending and receiving nurse are not engaged – this strategy will not be successful. All need to understand the focus of the experience is handing off a “Patient Relationship”
Next Steps:
References:

