

MMA QUALITY REVIEW

Physicians in pursuit of excellence

Handoff or fumble?

Minnesota physicians strive to prevent communication breakdowns during patient handoffs.

ROBERT MORAVEC, M.D., knows the chaos that can occur when communication breaks down between a physician discharging a patient from the hospital and the nursing home receiving that patient.

He recalls one case, in particular, when a physician did not complete a discharge summary for an elderly patient who had atrial fibrillation and required on-going anticoagulation to prevent stroke. Moravec says it took more than three days for the nursing home staff to discover the order was missing and to get the correct order.

The patient wasn't harmed, but "a lot of rework had to be done," says Moravec, medical director at St. Joseph's Hospital in St. Paul. "And there was a lot of potential for error and patient mismanagement."

Such scenarios, in which patients leave the hospital without adequate discharge information, aren't unusual.



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The Joint Commission has made improving patient handoffs a top patient safety goal.

A literature review published in the February 2007 issue of the *Journal of the American Medical Association* found that nationally the availability of a discharge summary at the first post-discharge visit was low (12 percent to 34 percent) and at four weeks after discharge remained poor (51 percent to 77 percent), affecting the quality of care in approximately 25 percent of follow-up visits.

Because handing off a patient from one provider to another can easily be fumbled, quality organizations such

as The Joint Commission have made improving handoffs a top priority. "The next evolution of quality improvement in health care is around care transitions and care coordination," says Jennifer Lundblad, president and CEO of Stratis Health, a nonprofit quality improvement organization in Bloomington.

Research supports the shift. Half of all patients experience at least one error during the post-discharge period, according to a study in the August 2003 *Journal of General Internal Medicine*. And The Joint Commission has docu- ▶▶

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mented that the vast majority of adverse events that patients experience result from poor communication among providers.

There's no consensus on best practices, yet. But quality experts have recognized that health care's version of the grapevine game needs some shoring up. Here are some ways providers in Minnesota and other parts of the country are trying to create systems for relaying critical information.

Better discharge summaries and plans

For years, Mayo Clinic has required a discharge summary for every patient leaving its Rochester hospitals. But Michael Rock, M.D., chief medical officer and medical director for Saint Mary's Hospital and Rochester Methodist Hospital, recalls many post-discharge scenarios where patients didn't take prescribed medications or received duplicate medications because the referring and receiving providers didn't exchange information. Similar communication breakdowns have led to duplication of lab work, unavailability of imaging studies, and worse—all of which Rock says can increase patient risks, inefficiency, and costs.

To improve the process, Mayo has emphasized that physicians—along with

nurses, dietitians, physical therapists, and other providers who write discharge orders—enter notes into the electronic medical record system by the time of discharge. The goal is to have “the receiving service know fully what was done, the current status of the patient, and what is expected for ongoing management,” Rock says.

Mayo also increased the frequency of its audits to measure the quality of discharge summaries from twice a year to monthly. Mayo's quality office staff surveys referring physicians and other community providers about the accuracy, completeness, conciseness, and relevancy of notes in the summaries.

Other institutions are focusing on creating standard discharge forms. A Medicare requirement to document and provide specific discharge instructions to heart failure patients about activity, diet, follow-up care, medication, worsening symptoms, and weight has prompted HealthEast to create similar discharge forms for patients with diabetes, kidney failure, and pneumonia.

A standardized approach

In January 2006, The Joint Commission started requiring hospitals to implement a standardized approach to handoff com-

How does NASA do handoffs?

RESEARCHERS from several universities observed handoffs in places where they have to be flawless, such as the NASA Johnson Space Center, two Canadian nuclear power plants, a railroad dispatch center in the United States, and an ambulance dispatch center in Toronto.

Here are handoff strategies these organizations use:

- Face-to-face verbal update with interactive questioning
- Outgoing person presents data in the same order every time
- Outgoing person provides written

summary of shift activities

- Interruptions limited during update
- Topics initiated by both the incoming and the outgoing person
- Incoming person assesses current status and historical data
- Incoming person reads back received information
- Transfer is delayed until critical activities are finished. ▀

Patterson, ES. Handoff strategies in settings with high consequences for failure: lessons for health care operations. *Int J Qual Health Care.* 2004;16(2):125-132.

munications. The most common strategy for achieving this is a model called SBAR, which stands for Situation, Background, Assessment, and Recommendation. SBAR can help providers organize their written and verbal handoffs so they are concise but still include all the important information. The SBAR model can be integrated into paper forms or electronic health record systems, or it can be used as a conversation guide.

In a recent survey, 66 percent of Association for Healthcare Accreditation Professionals members said their organization used SBAR. For example, Wilder Home Health Care in St. Paul started having its nurses use the technique when communicating with physicians in 2007 and saw a decrease in rehospitalization rates (see “A Framework for Clarity,” p. 12).

Nationally, providers have been developing other models for formalizing handoffs. For example, internal medicine residents at the University of California San Francisco Medical Center learn the ANTICIPATE method for organizing written sign-outs. Sign-outs should include Accurate administrative information such as the patients name, number, and location; New information in the form of a clinical update; Tasks or a to-do list; a subjective assessment of the severity of the illness; and Contingency plans for anticipated problems.

An electronic solution

In clinics, primary care physicians and specialists are often dissatisfied with the timeliness and content of referral letters and follow-up consultations. Harvard researchers conducted an email survey of physicians and found that 68 percent of specialists didn't receive information from primary care physicians about specific referral visits. Thirty-eight percent of the specialists said that such information would have been helpful, according to the results, which were published in the September 2000 *Journal of General Internal Medicine*.

In addition, four weeks after the referral visits, 25 percent of the primary care physicians had not heard back from specialists. Physicians cited the time required to create adequate notes as the main barrier to better communication.

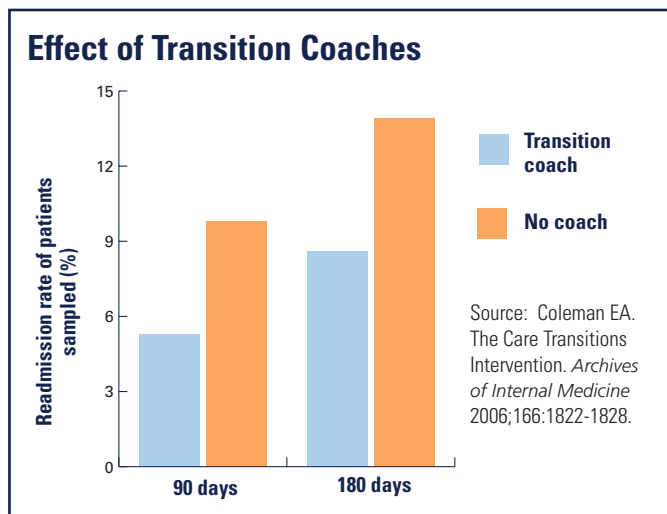
One possible solution the authors advocated was using electronic health records that could automatically produce and transmit referral letters. In Minnesota, some say a statewide system of interoperable electronic medical records will make handoffs easier. Minnesota has already mandated that an interoperable system be in place by 2015.

The Minnesota Health Information Exchange, a private-public partnership made up of the Minnesota Department of Health, Allina Hospitals and Clinics, the state's largest insurers, and others, was created in September of 2007 to build a network that will allow transmission of some information, such as prescriptions and lab results, between institutions. “If we had at the state level or the national level an effective, universally accessible health information management system that was patient-specific, all of this would go away,” Rock says.

Transition coaches

Another approach to improving handoffs is to hire a transition coach, a nurse, social worker, or other provider who can repair any communication breakdowns that occurred when the patient left the hospital.

Research has shown that transition coaches can keep patients from being readmitted to the hospital. University of Colorado researcher Eric Coleman, M.D., followed patients age 65 years and



older with complex illnesses treated in a Colorado system and found that those with transition coaches had lower rehospitalization rates, according to a report in the September 25, 2006, *Archives of Internal Medicine* (see chart “Effect of Transition Coaches”).

Locally, Allina Hospitals and Clinics and HealthEast Care System recently began using transition coaches. HealthEast piloted its program with one nurse transition coach in September of 2007. The coach worked mostly with frail, elderly patients with conditions such as congestive heart failure, diabetes, lung disease, hip fractures, and stroke.

At the end of the five-month pilot in February of this year, HealthEast found that the use of transition coaches significantly reduced rehospitalization rates (see “Following Patients Home,” p. 8), and was encouraged enough to expand the program.

The race to improve communications concerning medical handoffs probably won't be won with one or even several initiatives or practices. Rather, HealthEast's Moravec says it will require a shift toward “a culture of communication,” where providers will be expected to communicate with each other and have the tools to do so every time they pass the baton. ▀

By John Share

Freelance writer, St. Louis Park

Getting the meds right

Health care providers seek path to perfect medication reconciliation.

PHARMACIST STEVE MEISEL still cringes when he recalls a case that occurred 10 years ago at a Fairview hospital. A woman was hospitalized for internal bleeding after taking an incorrect dose of warfarin. She was treated and released, but she ended up back at the hospital a week later because her dose was never changed. “There were no clear orders. She wasn’t told to take a different dose, no one did the reconciliation work,” says Meisel, director of medication safety for Fairview Health Services. “Those are the kinds of bad outcomes that can happen.”

Such problems are not uncommon. A study published in the March 2005 issue of the *American Journal of Nursing* blamed poor medication reconciliation, for 46 percent of all medication errors and up to 20 percent of adverse events in hospitals. The Institute for Healthcare Improvement and The Joint Commission made improving medication reconciliation a top priority for hospitals and clinics in 2006.

Hospitals sometimes fail to do medication reconciliation, which is the process of ensuring continuity of all medication therapy at all transition points, because it is not always clear whose job it is and because it can be tedious and time-consuming work that is not reimbursed.

Fairview has been focusing on the issue since 2004, and they’re finding their efforts are paying off.

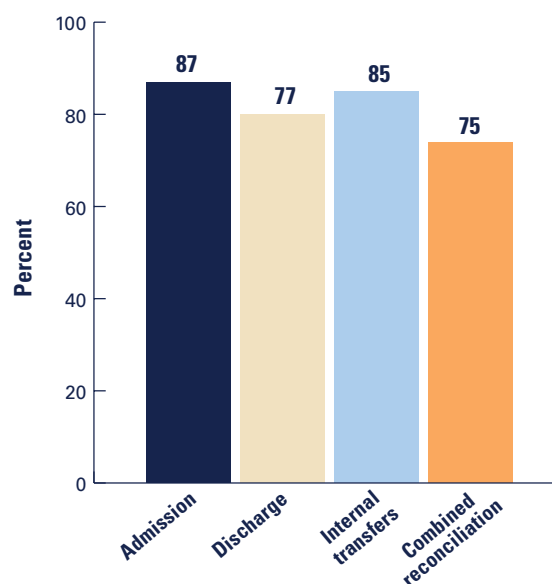
Big gains at small hospitals

Last December, Fairview’s Northland Medical Center in Princeton was among six winners of the Institute of Health Care Improvement’s Medication Reconciliation Challenge, a project recognizing best practices. Although not a winner in the challenge, Fairview Lakes Regional Medical Center in Wyoming, Minn., has dramatically improved its medication reconciliation rates as well.

Both hospitals boosted their medication reconciliation rates from about half of patients in 2004 to more than 95 percent of patients in 2007. The hospitals effectively implemented techniques that Fairview has been promoting and developing since 2004 (see “Step by Step,” p. 5).

Meisel says those techniques include getting medical leaders to support medication reconciliation, developing useful

Fairview’s 2007 systemwide hospital medication reconciliation rates



Source: Fairview Health Services

forms and processes, and defining who is accountable to do what when. Getting the accountability part right is the most important piece, Meisel says. Fairview’s systemwide policy is to have nurses take a medication history when patients are admitted to the hospital. “If you don’t have a good starting list, you can’t do anything, and creating such a list requires a good conversation with the patient,” Meisel says.

The attending physician is accountable for reviewing that list and making decisions about whether to continue or discontinue the medications, or put them on hold. The pharmacy enters these medications into the pharmacy computer along with all other physician orders. They then print the updated list for physicians to use when transferring and discharging patients. At discharge, they update the patient’s electronic medical record, and nurses are responsible for educating patients about any changes.

The hospitals created a form for taking a patient’s medication history that the attending physician can use to order,

change, or hold medications. To ensure that all this happens, Fairview audits 20 records a month.

Complex care, complex reconciliation

Although some of Fairview's hospitals have surpassed the organization's goal of achieving medication reconciliation rates of 90 percent, the composite score for all Fairview hospitals has remained at about 77 percent.

Meisel says that's because the process is harder at larger hospitals that deal with more complex cases, drug regimens, social situations, and provider relationships. Meisel gives the hypothetical example of a patient from North Dakota who arrives at the University of Minnesota Medical Center, Fairview with pneumonia but also has neurological problems and heart disease and has had a kidney transplant. To begin the medication reconciliation process, a nurse might have to call a clinic in North Dakota to track down a medication list.

Once the list is in hand, the attending physician might have to deal with more than a dozen common and obscure medications. The physician must make decisions about whether the patient should continue, discontinue, or put on hold the medications on the list. In such cases, Meisel says, "getting the initial drug list is hard, and finding someone capable of making decisions about the list is harder."

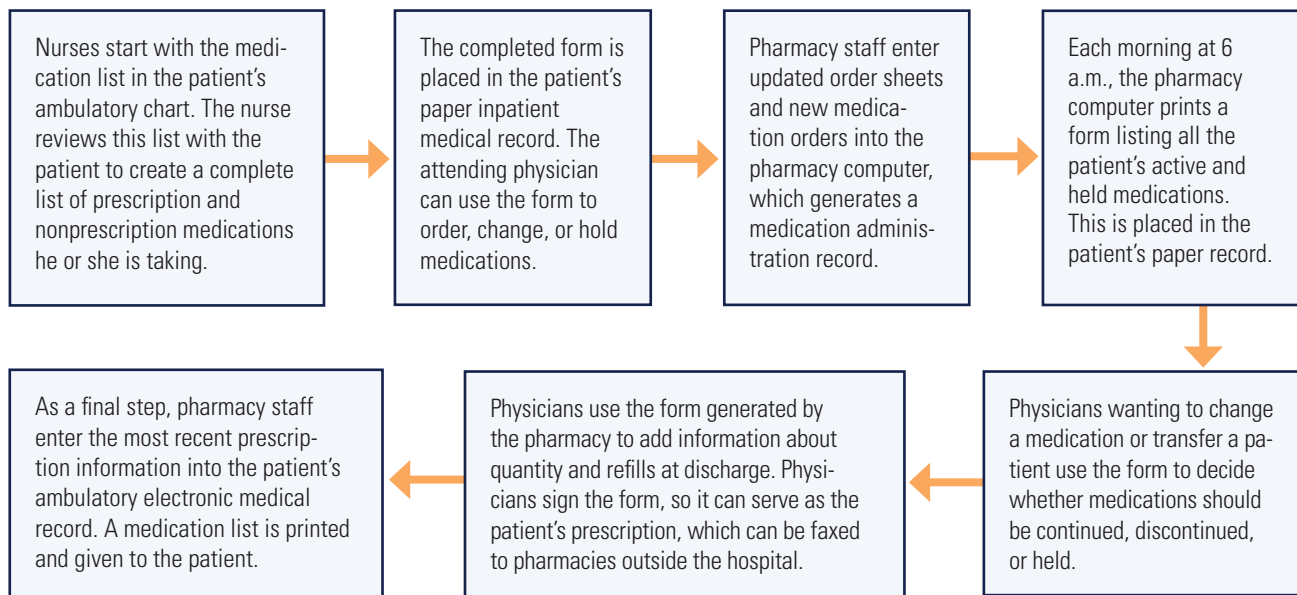
Meisel says that overcoming such difficulties ultimately is a matter of will and attitude. Leaders need to acknowledge that medication reconciliation can be a lot of difficult work, he says, but they also have to insist that it be done, and providers have to think about putting patients first.

"We all have seen patients who have suffered because of not doing this. So if we are patient-centered, then these barriers go away. If we are provider-centered, then that's where the barriers come from," Meisel says. ▀

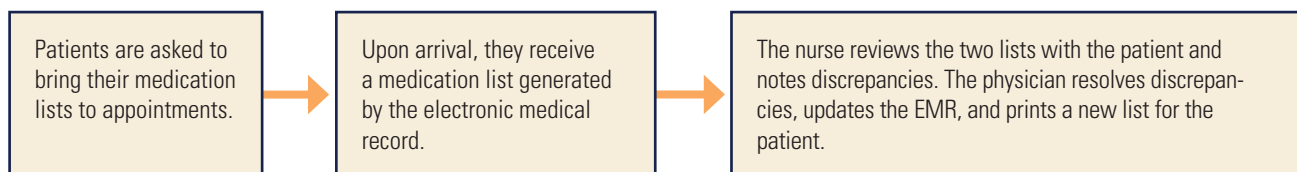
Step by step

Fairview's medication reconciliation process

At the hospital



At the clinic



NEWS

YOU CAN USE

Residents lack handoff training

Research says: Adverse events are linked directly to poor processes for transferring patient care responsibilities between physicians.

Fast fact: Of the 324 accredited internal medicine residency programs surveyed, 60 percent did not provide lectures or workshops on sign-outs. In 30 percent of those programs, residents received neither lectures, workshops, nor supervised on-floor training for completing written sign-outs.

Put it in practice: Residents



must learn systematic methods to manage transfers of care in internal medicine residency programs.

Source: Horwitz, Li. Transfers of Patient Care Between House Staff on Internal Medicine Wards: A National Survey. *Archives of Internal Medicine*. 2006;166:1173-1177.

Discharge summaries a key tool

Research says: Improvements are needed in how and when discharge information is transferred from hospital providers to primary care physicians.

Fast fact: Discharge summaries often lack important information such as diagnostic test results (missing from up to 63 percent of summaries), treatments (missing from at least 7 percent), discharge medications (missing up to 40 percent of the time), test results pending at discharge (missing from 65 percent of summaries), patient or family counseling (missing more than 90 percent of the time), and follow-up plans (missing up to 43 percent of the time).

Put it in practice: On the day of discharge, a summary document should be sent to the primary care physician by email, fax, or mail. If a complete discharge summary cannot be sent on the day of discharge, then an interim discharge note should be sent. At minimum, it should include the diagnoses, discharge medications, results of procedures, follow-up needs, and pending test results. ▀

Source: Kripalani, S. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *Journal of the American Medical Association*. 2007; 297(8):831.

Online resources and tools

Outpatient medication reconciliation

Safe clinic medication management requires participation by both patients and doctors. A tool kit developed by providers at Aurora Health Care in Wisconsin outlines the steps necessary to create a patient-centered medication reconciliation process and provides specific templates and resources, including clinic process flow chart and forms. <http://patientsafety.org/page/109587/>

Help patients track their medications with a "pill card"

Patients are often confused about their medication regime and lose track of what they've taken each day. The Agency for Healthcare Research and Quality (AHRQ) has developed a pill card that uses pictures and simple phrases to aid patients. AHRQ provides sample clip art, a template, and step-by-step instructions for creating this patient aid. www.ahrq.gov/qual/pillcard/pillcard.htm

Help your patients prepare for medical appointments



This brochure helps patients and caregivers take an active role during medical appointments. www.ahrq.gov/qual/beprepared.pdf

From the malpractice files

Poor communication contributes to misdiagnosis.

MISTAKES ARE OFTEN THE BEST TEACHERS. Here's a case from the files of the Midwest Medical Insurance Company that illustrates how a communication error can contribute to a bad outcome.

Case Study: A 52-year-old woman arrived in the emergency department in the early morning complaining of vague abdominal discomfort, nausea, and back pain. The previous day she saw her family physician and said she was experiencing painful urination and back pain that radiated to her right flank. The family physician diagnosed cystitis but also suspected atypical appendicitis and prescribed antibiotics. He told her to go to the emergency room if her symptoms persisted, which she did.

Upon admission, she was afebrile. The emergency physician ordered a urinalysis, abdominal X-rays, and labs. Her white blood cell count and X-rays were normal, and her urinalysis was negative. The emergency physician requested a surgical consult. The surgeon examined the patient, noting that she had abdominal pain without involuntary guarding. But he concluded that she did not have appendicitis. The surgeon and the family physician agreed to admit the patient for observation of right-sided abdominal pain and suspected gastroenteritis.

That afternoon, the patient complained of groin pain radiating to her right flank. A nurse notified the family physician, who came to the hospital. The family physician performed a pelvic exam, which was unremarkable, and ordered pain medication. Two hours later, the nurse called him again because the patient was experiencing severe pain. He increased the pain medications and repeated the lab work. The lab results showed an increase in her white blood cell (WBC) count to 11,000 per microliter. The family physician then ordered a CT scan for the next morning but did not notify the surgeon of the change in the patient's status. During the night, the nurse called the physician again to report increased pain. The doctor ordered more pain medication.

The next morning, the CT showed inflammation of the patient's appendix and a possible abscess. The family physician again contacted the surgeon. The surgeon operated on the patient and found a ruptured retrocecal appendix. He estimated that the rupture happened six to 10 hours before surgery.

During surgery, the patient became hypotensive and showed signs of septic shock.

After surgery, the patient became gravely ill, developed adult respiratory distress syndrome, and died after a five-month hospitalization. Her family filed a malpractice claim against the family physician and the surgeon, alleging failure to conduct appropriate examinations, failure to order appropriate studies, failure to recognize appendicitis, and failure to treat the patient's symptoms in a timely manner.

Outcome: A jury awarded almost \$2 million in damages to the family and assigned 80 percent of the fault to the family physician and the rest to the surgeon.

The jury said the family physician should have communicated the patient's changing condition to the surgeon or returned during the night when the patient continued to have severe pain. The jury thought the surgeon should have done more to find the cause of the patient's pain and specifically should have ruled out a potentially serious condition such as appendicitis.

Risk Management Perspective: Experts agreed this was an unusual presentation for appendicitis but criticized the physicians for not ordering an abdominal CT, which could have ruled out the appendicitis. They were especially critical of the lack of communication between the family physician and the surgeon when the patient began complaining of increasing pain and her WBC count increased.

Risk Management Tip: Communicate with primary care and/or consulting physicians when a patient has a change in condition.



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Following patients home

Coaching patients can prevent boomerang trips to the hospital.

SOMETIMES IT TAKES a home visit to find out what medications a patient is really taking.

That is one of the lessons registered nurse Ruth Ratajczak has learned as a transition coach at HealthEast's St. John's Hospital in Maplewood.

In particular, Ratajczak recalls one patient, who had been hospitalized for chest pain and was double-dosing himself at home. During a home visit, Ratajczak noticed he was still taking his old drugs in addition to the new ones his doctor in the hospital prescribed. When she asked him why he was still taking the old medications, the patient responded that his primary care doctor told him he was to take those drugs for the rest of his life.

Minnesota hospitals increasingly enlist the aid of transition coaches like Ratajczak. Transition coaches work with patients after they leave the hospital to ensure they follow postdischarge instructions, recognize if their condition is worsening, and take their medications correctly.

Hospitals are finding them necessary because of the complex and disjointed nature of modern medical care and the difficulty patients, particularly elderly patients, have comprehending what they need to know to know about caring for themselves at home, says Pennie Viggiano, HealthEast system director for government special populations.

"Although each site in the care system might do a phenomenal job, if we don't help hold their [patients'] hands through the transitions, we will continue to fail them," she says. HealthEast started piloting a transition coach program at St. John's in September of 2007. Patients were chosen for the pilot from any of four HealthEast primary care clinics. To qualify for the transition coach program, they had to be 65 or older and have conditions such as congestive heart failure, diabetes, lung disease, hip fractures, stroke, or medical back pain.

By February of 2008, 86 patients had been through the pilot. Typically, this group would be hospitalized two to three times, during any six month period. But during the pilot, the coached group took one less trip to the hospital, with a 1.42 per person rehospitalization rate. The control group's rate was 2.53 rehospitalizations. Those results prompted HealthEast to hire another transition coach in addition to Ratajczak. "Our



Photo by Bill Kelley

Transition coach, Ruth Ratajczak, R.N., visits with Lois Nelson in the hospital and later in her home.

future vision is that all of our patients will have their needs assessed, and if they need assistance, we would be able to set up some sort of structure for them," Viggiano says.

The Colorado approach

HealthEast uses the transition coach model championed by the University of Colorado's Eric Coleman, M.D. His model is based on four elements: home visits, providing patients with a personal health record, educating them about warning signs related to their condition, and medication reconciliation.

Ratajczak visits patients before their discharge and gives them a personal health record that includes a list of their providers and medications. Within two days of their discharge, she visits them at home, where she educates them about "red flags" that indicate their condition is worsening. She also reconciles the medications they received in the hospital with the ones they were taking before and attends to other needs such as arranging for meals or home care.

Visiting patients at home is also one of the most valuable

parts of the coaching, she says.

“To be able to sit in their home and see how they maneuver around—Do they use their walker, or their oxygen? Are their medications lined up on the kitchen counter, or are they scattered all around? This is really helpful,” she says.

After the home visit, Ratajczak does a phone check one and two weeks later. During the pilot, she continued to check in with patients for three weeks to three months. If a patient needs additional assistance, she refers them to a HealthEast care manager.

As a transition coach, Ratajczak can bridge the gap between the patient’s inpatient and outpatient care. For example, she worked with another patient whose blood pressure medication was switched in the hospital. When the patient got home, “the first thing the wife did was put him

back on the medication the primary care doctor had prescribed.” Ratajczak tried to “coach” the wife out of doing this but failed. Because she had access to the patient’s medical record, she wrote a note to the primary care physician, alerting him to the situation.

Ratajczak also helps patients act as their own advocate. She remembers a case in which a patient described “red flag” symptoms for a bladder infection during their phone conversation. Ratajczak told the woman to call her doctor, who prescribed antibiotics. Without the call from the patient, the infection could have easily landed the patient in the hospital, she says. “Especially with seniors, you almost need to give them permission to jump in and make a call, otherwise they have this mindset that they will just wait and ask their doctor when they get a chance,” she says. ▀

Medication list catches on

Promoting My Medicine List pays off in northern Minnesota.

MINNESOTA’S ROSEAU COUNTY along the Canadian border has approximately 16,000 residents and about 4,000 My Medicine Lists.

My Medicine List is a standardized medication reconciliation form developed by the MMA, the Minnesota Alliance for Patient Safety (MAPS), and about 50 other organizations, which allows patients to record all the medicines, vitamins, eye drops, and herbal remedies they use.

Marilyn Grafstrom, R.N., director of quality and risk management for LifeCare Medical Center, a 25-bed critical care hospital in Roseau, says the forms are a low-tech approach for improving medication reconciliation that has been paying off for her organization.

In January 2007, the medical center started aggressively distributing My Medicine Lists to patients and nonpatients at pharmacies, fairs, and through two of the county’s large employers, Polaris Industries and Central Boiler.

“I would say we’ve distributed about 4,000 of the lists, and we are really starting to see them show up pretty consistently now after pushing them for a year,” Grafstrom says.

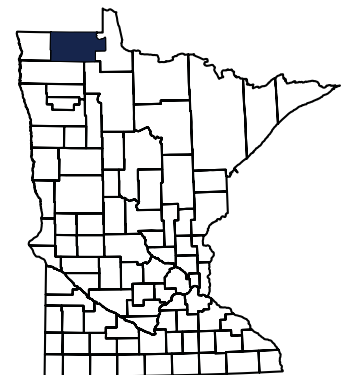
LifeCare has been trying to encourage patients to fill out the wallet-sized forms because the biggest medication reconciliation barrier has been the initial compilation of

medications upon admission. Sometimes nurses would spend as much as an hour calling pharmacists to track down prescription information.

Grafstrom says nurses are buying into the program because it streamlines the process.

Grafstrom says it may sound outdated to have providers cross out medications and write new ones on a paper list, but it will have to do until an integrated electronic medical system is available—an event she isn’t expecting any time soon. LifeCare would need an international system because some of its patients see Canadian doctors.

“We are just not at a place with health care where we can share medication data with each other, but our patients still want us to know what medications they are on,” she says. ▀



Increasingly, patients in Roseau County are carrying a list of their medications because of My Medicine List, which is available at www.mnpatientsafety.org.

MINNESOTA & NATIONAL ROUNDUP

Care the Rochester way could save the U.S. billions

MAYO CLINIC IN ROCHESTER provides better patient care at a lower cost than other top U.S. health care institutions, according to the Dartmouth Atlas of Health Care which tracks the care of patients with severe chronic illness.

The cost and quality of end-of-life care varies greatly across the country and much of the end-of-life care that is provided may add billions of dollars in cost without improving outcomes, according to the research by the Dartmouth Institute for Health Policy

and Clinical Practice.

The Atlas project studied records of millions of Medicare enrollees with severe chronic illnesses who died between 2001 and 2005.

If the spending per patient everywhere mirrored that in Rochester, the government could have saved \$50.1 billion, or 17.3 percent of all spending, on these patients alone. Learn more about Medicare data at www.dartmouthatlas.com. ▴



Medicare data shows that the cost of care in Rochester, Minnesota, is lower than in other parts of the country.

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Angie's List rates doctors

MINNESOTA DOCTORS have already been praised for finding scalding skin staph infections and panned for missing skin cancer on Angie's List.

The online service that offers personal reviews of plumbers, roofers, landscapers, and car mechanics, included ratings of doctors earlier this year.

Angie's List customers can see if area doctors earned A's or F's in categories such as office cleanliness, wait times, and how well they listen. Members also write reviews, detailing exactly what they liked or didn't like. ▴

Quality reporting may get easier

IN APRIL, the Centers for Medicare and Medicaid Services announced changes to its 2008 Physician Quality Reporting Initiative (PQRI) that should make it easier for physicians to participate in the program that offers a potential bonus payment of up to 1.5 percent of total charges.

As part of a pilot project, Medicare will allow clinics to submit their quality data by using selected organizations that maintain medical registries such as the National Cardiovascular Data Registry.

Medicare is also conducting a similar

pilot, in which data can be submitted using electronic health records.

The pilots are testing whether these methods could replace the existing method that relies on G-codes and CPT-II codes.

More than 100,000 providers participated in the voluntary program in 2007. Medicare reports that more than half of these participants are on track to receive a 0.5 percent bonus.

For more information on PQRI, visit www.cms.hhs.gov/PQRI. ▴

Medica to try health coaches



THIS FALL, Medica will launch a comprehensive, in-house health coach program for members with claims of more than \$20,000 a year, according to a Medica press release.

The program will replace Medica's existing disease management program, which is provided by an outside vendor.

The health coaches will collaborate with members to plan treatment and

self-care that take into account all of the patient's medical issues, according to Medica.

Medica will identify members for the health-coaching program based on claims data, provider referrals, self-referrals, and health-risk assessments.

Medica's in-house health coaching program will work in coordination with its clinic-based chronic care program,

which was launched late last year. In that program, participating clinics focus on a specific chronic condition that matches with their patient base and improve their ability to deliver care management for those conditions. ▀

Medicare may not pay for hospital-acquired conditions

MEDICARE is considering adding more conditions related to poor hospital care to its list of conditions that it will no longer pay for, starting in October.

The proposed additions include:

- Blood clots in the vascular system
- Bloodstream infections
- Ventilator-associated pneumonia
- Legionnaire's disease
- Delirium
- Collapsed lung as a result of medi-


cal treatment

- Clostridium difficile-associated disease
- Extreme blood sugar derangement

Medicare already has adopted a policy to not pay hospitals for conditions caused by mistakes, known as "never events," such as wrong site surgeries, falls, and medication errors.

For more information on the proposed rules, visit www.cms.hhs.gov. ▀

Nominate a doctor for the 2008 MMA Physician Leadership in Quality Award



NOMINATIONS are being accepted for the 2008 MMA Outstanding Achievement Awards, including the third annual Physician Leadership in Quality Award. This award recognizes physicians who have advanced quality and safety in health care in Minnesota or in their practice.

The awards will be

presented at the MMA's 155th Annual Meeting, September 17-19 in St. Paul.

For more information or to nominate someone, visit the MMA website at www.mmaonline.net. All nominations must be received by July 9, 2008.

Nominations can be emailed to vwestling@mmmed.org, faxed to 612/378-3875, or mailed to Awards, Minnesota Medical Association, 1300 Godward St. NE, Suite 2500, Minneapolis, MN 55413. ▀

Upcoming events

Conferences

2008 Minnesota E-Health Summit

June 26, 2008 in Brooklyn Center, MN. For more information and to register, go to www.health.state.mn.us/e-health/.

MMA Annual Meeting 2008

September 17-19, 2008 in St. Paul, MN. For more information and to register, go to www.mmaonline.net.

Minnesota Alliance for Patient Safety Conference

November 13-14, 2008 in Brooklyn Center, MN. For more information and to register, go to www.mnpatientsafety.org.

Grants and Funding

Application deadline for MDH Electronic Health Record Grant Program

September 5, 2008, For more information, go to www.health.state.mn.us/divs/orhpc/funding/index.html#ehr.

Electronic Health Record System Revolving Loan Program

Minnesota Office of Rural Health and Primary Care, ongoing. For more information, go to www.health.state.mn.us/divs/orhpc/funding/index.html#ehr.

A framework for clarity

Home health agency finds SBAR technique results in better care.

THE WILDER HOME HEALTH AGENCY, which serves about 600 clients a year in St. Paul and the surrounding suburbs, found that its hospital readmission rates fell after its nurses started using the SBAR model for communicating with doctors.

The acronym SBAR, which stands for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation, is a roadmap that providers can use to communicate with each other. It was originally developed by the U.S. Navy for use among the crews of nuclear submarines. One of the goals of SBAR is to make sure important information doesn't get lost in translation.

In March of 2007, after a staff member learned about it at a Stratis Health conference, Wilder started training its approximately 20 nurses and other staff to use the SBAR technique for both internal and external communications. They printed laminated cards with preselected questions to use in different situations.

Mary Ann Mastel, R.N., director of home health and supportive services, says the effort has been successful. Since implementing SBAR, the organization has seen its patient satisfaction scores increase and its hospital readmission rates decline.

Between March and November of 2007, the organization's hospital readmission rate dropped from 25 percent of patients to about 17 percent. The national average for home health care organizations is 28 percent. Mastel says a number of factors could have caused the change, but she likes to believe improved communication played a part.

For sure, she knows the SBAR model is popular with nurses, who say it helps them organize their thoughts and ensures they hit all the necessary bases when discussing a patient's care, including making care recommendations to the doctor.

How does SBAR help structure the conversation?

Situation: What is happening at the present time? Identify self, patient, and briefly state the situation.

Background: What are the circumstances leading up to this situation? Most recent vital signs, lab results, other clinical information.

Assessment: What is the problem?

Recommendation: What should be done to correct the problem? Recommend transfers, visits, tests, order changes, or other actions.



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Free online SBAR training

The Institute of Health offers free online training and materials. Registration is required. www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

"The feedback I hear is that [the nurses] really like the recommendation piece. It gives them the feeling that it is an acceptable thing for them to be making a recommendation to a physician," Mastel says.

This is especially important in home health care settings, where the doctor may not have seen the patient for several months, whereas the nurse has seen the patient every week for several years.

"The nurse can say 'the client's weight has increased five pounds in the last week and her breathing is a lot more labored, maybe you want to increase her diuretic,'" Mastel says.

In this way, clear communication between the nurse and the doctor can keep patients with conditions such as heart failure, pneumonia, wounds, and infections out of the hospital.

Mastel remembers one particular patient with congestive heart failure, hypertension, and diabetes who was frequently in and out

of the hospital. At first, the home health nurse and the physician rarely communicated, and the nurse would learn of hospitalizations after the fact. After going through SBAR training, the nurse told the physician her view of the situation, and together they came up with a treatment plan. The doctor also increased the frequency of the nurse's visits so that she could keep a closer eye on the patient.

"Having those additional visits with the client, the nurse was able to more precisely communicate the client's condition, so the doctor could make medication changes, instead of everything becoming a crisis," Mastel says.

Mastel says that each nurse probably uses the SBAR template differently, with some jotting down notes before they make a call and others just running through it in their head. "It can be a helpful guide for the nurse," she adds, "because there is going to be a lot of information to convey with a complex patient." ▀