New England Home Health Collaborative

Clinical Collaboration: Partnering with Physicians

Kathryn D. Roby, M.Ed., M.S., CHCE, CHAP
QIN-QIO Home Health Consultant

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brought to you by:

• **Healthcentric Advisors**
  – Focus areas: MA, ME, RI

• **Qualidigm**
  – Focus areas: CT, NH, VT
Please visit the New England QIN-QIO website!

www.healthcarefornewengland.org
Introducing the New England QIN-QIO

The New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO) is a collaborative effort to improve the experience, care, and health outcomes for all.
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Upcoming Events

WEBINAR: New England Home Health Care Collaborative - Session 3: Use of Aspirin in Heart Disease
UPCOMING EVENTS

WEBCAST: New England Home Health Care Collaborative – Session 3: Use of Aspirin in Heart Disease
April 8th @ 2:00 pm - 3:00 pm

WEBCAST: Ensuring Every Transition is a Safe Transition – A Community Approach
April 17th @ 11:00 am - 12:00 pm

Home Health

The New England QIN-QIO offers free evidence-based resources to home health providers to improve cardiac health and reduce hospitalizations for patients with cardiac disease. Resources include tools, best practices, and educational events to give home healthcare providers, community organizations, and patients the opportunity to share, learn, and make a difference. Learn more about the initiatives:

- **Cardiac Health and Million Hearts**
- **Improving Transitions in Care**
- **Medication Safety and Adverse Drug Event (ADE) Prevention**
Welcome New Members!

Connecticut

Kathy Roby  kroby@qualidigm.org

- Bayada Home Health Care
- Family Care Visiting Nurse and Home Care Agency, LLC
- Harriott Home Health Services, LLC
- Hartford Healthcare at Home
- New Milford VNA
- Totality Home Health Care Agency, LLC
- There For You
- UniCare, LLC
Welcome New Members!

Maine

Doreen Bedaw dbedaw@healthcentricadvisors.org

- Bangor Area Visiting Nurses
- Eastern Maine Homecare - Visiting Nurses of Aroostook
- Gentiva Certified Healthcare Corp
- Hancock County Homecare
- Maine General Home Care and Hospice
- Valley Home Health Services
- VNA Home Health & Hospice
- York Hospital Home Care
Welcome New Members!

Massachusetts

Pat Donovan McLeod pdonovanmcleod@healthcentricadvisors.org
Barbara Corning Davis bcorning-davis@healthcentricadvisors.org
Karen Evans kevans@healthcentricadvisors.org

- Abbott Home Health Care, Inc.
- Able Home Care, LLC
- ABP Best Home Care Agency, Inc.
- Afya Home Care, LLC
- Amigos Homecare, LLC
- Bayada Home Health Care (8)
- Brockton VNA
- CareGroup Home Care
- Deriviere Medical Corporation
Welcome New Members!

Massachusetts (cont.)

- Hallmark Health VNA, Inc.
- Home Again Health Care, LLC
- Home Health VNA, Inc.
- Medical Resources Home Health Corp. (3)
- Partners HealthCare at Home (5)
- Porchlight VNA
- Southcoast VNA, Inc.
- Trinity Home Care, Inc.
- VNA & Hospice of Cooley Dickinson
- VNA of Cape Cod, Inc. (2)
- VNA of Eastern MA
- Walpole Area VNA
Welcome New Members!

New Hampshire

Georgette Verhelle georgette.verhelle@hcqis.org
Leslie Molleur leslie.molleur@hcqis.org

- City of Berlin Home Health & Nursing Services
- Concord Regional VNA & Hospice
- Cornerstone VNA
- Newfound Area Nursing Association
- Pemi-Baker Community Health
Welcome New Members!

Rhode Island

Brenda Jenkins bjenkins@healthcentricadvisors.org

- Assisted Daily Living, Inc.
- Brookdale Living
- Capitol Home Care Network, Inc.
- Cedar Home Health, LLC
- Chartercare Home Health Services
- Concord Home Health Services
- Dependable Healthcare Services, LLC
- Life Care At Home of RI
- Pinnacle Home Care, LLC
Welcome New Members!

Rhode Island (cont.)

- Visiting Nurse Home Care
- VNA of Care New England
- VNA of Rhode Island
- VNS Home Health Services
- VNS of Newport & Bristol Counties, Inc.

Vermont

Gail Colgan gcolgan@qualidigm.org

- Manchester Health Services, Inc.
- Bayada Home Health Care
Why Today’s Topic?

*Not* the HHQI measure for reducing cholesterol levels.

Why not?

Because achieving improvement in this measure requires effective physician communication

Are we there yet?
Partnering with Physicians

• How well do we communicate with each other?

• Can we improve collaboration by improving communication?
Obstacles to Effective Communication

How do we perceive each other?

• Peer professionals or Team Captain vs. rookie recruit?

How do we present to each other?

• Professional and respectful?
• Abrupt, annoyed or chatty, overly friendly?

How can we establish open respectful communication with each other?
SBAR:
A Technique for Improved Communication
Our Prior Situation: S

Many clinical conversations are occurring about patient concerns without a clear purpose and even less of a direction.

“The train had left the station, unsure of it’s destination and with much trepidation.”
The Background: B

- Are your clinicians seeking validation, empathy and support regarding patient concerns?
- When difficult situations occur, do they quickly enter crisis mode?
- Clinicians have difficulty expressing their concerns in a clear and concise format.
- Are you using an expected, standardized, format for communication that is efficient and data driven?
Our Assessment: A

• We need a standardized and expected format for communicating patient concerns among disciplines.

• We need to provide a process for our clinicians to discuss patient concerns with physicians and all members of the care team.

• We need to get beyond the emotional components of our patient discussions to accurately address the clinical components.
We Recommend: R

Adopt the SBAR format for communicating patient concerns in a professional, concise, and data driven manner.

Patient Safety First
SBAR Technique: The Details

**S = Situation**
What is going on with the patient? A concise statement of the problem.

**B = Background**
What is the clinical background information that is pertinent to the situation?

**A = Assessment**
What did you find? Analysis and considerations of options.

**R = Recommendation**
What action/recommendation is needed to correct the problem? What do you want?
Transform Communication: How?

Consider the factors that affect how we communicate:

**Education**
- Nurses are taught to be narrative and descriptive
- Physicians are taught to be problem solvers and want only the “headlines”
- Others?

**Teamwork**
- Nurses do not necessarily see the care environment as collaborative
- Physicians tend to view the care environment as fairly collaborative within their discipline
- Others?
Assertion Cycle:

A model to guide and improve assertion in the interest of patient safety*

SBAR Technique: Step 1

Ensure all pertinent patient information is available before you contact the physician.

- Name
- Medical record number
- Age
- Diagnosis
- Medication list
- Allergies
- Vital signs
- Lab results
- Advance Directive
SBAR Technique: Step 2

Ensure a physical assessment has been completed

Have I:

- Seen and assessed the patient myself before calling?
- Reviewed the chart for appropriate physician to contact?
- Completed phone monitoring, tele-monitoring or tele-triage?
SBAR Technique: Step 3

When calling the physician, use the SBAR technique and tool:

\[(S)\textbf{ Situation:}\]

What is the situation you are reporting?

- Identify self, agency, patient, patient location.
- What is going on with the patient. A concise statement of the problem.
SBAR Technique: Step 3 (cont.)

(B) Background:

What is the clinical background information that is pertinent to the situation?

- The admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, etc.
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Advance Directive
(A) **Assessment:**

- What are the clinician’s findings?
- What is the analysis and consideration of options?
- Is this problem severe or life-threatening?
SBAR Technique: Step 3 (cont.)

(R) **Recommendation:**

- What action/recommendation is needed to correct the problem?
- What solution can you offer the physician?
- What do you need from the physician to improve the patient’s condition?
Bring SBAR to your Agency

• The Pre-Test
  – Use the patient scenarios to assess how your staff would communicate today

• The Education
  – Use ten slides (19-29) as your training

• The Post Test
  – Replay actual patient scenarios to test your staff’s ability to report in SBAR fashion
  – Validate staff competency
SBAR

Patient Scenario:

Staff Training Tool
Mr. Nelson is a 71 year old male with a history of HTN and COPD.

For the past 2 days, the patient c/o being “tired” and “weak”

Post RN assessment, it is determined that he has had episodes of syncope with sudden movements, for the last 1-2 days after starting “that new medication”
SBAR Exercise cont.

The nurse discovers that the patient’s “new medication” was filled at a different pharmacy, and was really the same antihypertensive he was already taking.

- **Supine BP:**
  - 102/60 (R); 106/62 (L)
  - Pulse: 72

- **Standing BP:**
  - 90/52 (R); 96/58 (L)
  - Pulse: 86; R: 24

- **Previous VS:**
  - 164/82 (R); 158/80 (L);
    - Pulse: 68; R 22
SBAR Exercise: MD Contact

**Situation:**

Dr. Smith, this is Nancy Nurse from ABC Home Care.

I am calling about Mr. James Nelson, your 71 year old patient who is now having episodes of syncope.
Background:

- ABC Home Health has been seeing Mr. Nelson for the last 3 weeks for exacerbation of HTN.
- Previous vital signs were 164/82(R), 158/80 (L), P 68, R 22 (sitting).
- Mr. Nelson has been complaining of lightheadedness, weakness and syncope with sudden movement.
- VS today were: BP 102/60(R), 106/62(L) sitting, 98/52(L standing) P 72, & R 24.
- I discovered that the patient was taking a double dose of his antihypertensive medication for the last four days by accident.
Assessment:

The patient accidentally had a refill of the same antihypertensive medication filled at another pharmacy. He is hypotensive from the medication error.
**SBAR Exercise: MD Contact Cont.**

**Recommendation:**

I would like to hold his BP medication until tomorrow and schedule two extra skilled nursing visits starting tomorrow to recheck his blood pressure and for medication teaching. What are the parameters for restarting the medication?
SBAR (Physician Communication)

Have ALL information AVAILABLE when reporting:
chart, allergies, medication list, pharmacy number, pertinent lab results

SITUATION
I am calling about: _____________________________ (patient’s name)
The problem I am calling about is: _____________________________

BACKGROUND
State the primary diagnosis & reason patient is being seen for home care: _____________________________
State the pertinent medical history: _____________________________
Most recent findings: _____________________________
Mental status _____________________________ Neuro changes _____________________________ Temp _____________________________
BP _____________________________ Pulse rate/quality/rhythm _____________________________ Respiration/quality _____________________________
Lung sounds _____________________________ Pulse Oximetry% _____________________________ Oxygen _____________________________ L/min via _____________________________
GI/GU changes (nausea/vomiting/diarrhea/impaction/hydration) _____________________________
Weight _______ (actual) Loss or Gain _______ Skin color _____________________________ Blood Glucose _____________________________
Wound status (drainage, wound bed, treatment) _____________________________
Pain level/location/status _____________________________
Musculoskeletal changes (weakness) _____________________________
DNR Status _____________________________
Other _____________________________

ASSESSMENT
(What do you think is going on with the patient?)
I think that the patient is: _____________________________
I am not sure of what the problem is, but the patient’s status is deteriorating.

RECOMMENDATION
I suggest or request:
☐ PRN visit or referral: ☐ Nurse ☐ PT ☐ ST ☐ OT ☐ HH Aide ☐ MSW ☐ Dietician
HHQI Data Collection

Have you registered your agency on the HHQI Cardiovascular Data Registry yet?

Have you selected your measures?

Have you described this project, your agency goals and the data collection process to staff?
Making Data Collection Easier

Include the HHQI Literature in admission packets

Insert Data Collection Tool in the chart for staff to begin on admission, complete on discharge

Central location for completed tools to be entered in the HHCDR
Million Hearts® Campaign

• How can your agency support C-V risk reduction and medication compliance?

• Agency sponsored exercise (Noon time walkers)

• Company support of weight loss aids
Peer-to-Peer Sharing

• What is working well?

• Goal: to improve the outcomes of our patients episodes of care.

• By working together, sharing ideas, helping one another, everyone’s outcomes will improve.

• Sharing processes, suggestions, ideas on monthly webinars
HHQI Cardio LAN

• Every third Thursday, an educational webinar is offered by HHQI related to this project

• Have your registered for this month’s webinar?
  – Thursday, May 21 at 2:00 PM

• HHQI website – archived webinars
Q & A

How can we help you?
Next Webinar

New England Home Health Collaborative: Improving Patient Engagement

Wednesday, June 10, 2015
2:00 - 3:00 PM
Contact

Kathryn D. Roby, M.Ed., M.S., CHCE, CHAP
QIN-QIO Home Health Consultant
Phone: 860-632-3724
Fax: 860-632-5865
E-mail: kroby@qualidigm.org