Cathy Barry-Ipema, The Joint Commission: Hello and welcome to the Joint Commission Center for Transforming Health Care news conference about improving transitions of care and hand-off communications. Our speakers today are Dr. Mark Chassin, president of The Joint Commission; Dr. Michael Aylward, University of Minnesota assistant professor of medicine, Fairview Health Services; Michael Dowling, president and CEO of Northshore LIJ Health System; Susan Mullaney, CEO of Kaiser Permanente/Sunnyside; Dr. Kevin Tabb, chief medical officer of Stanford Hospital and Clinic; and Grant Wicklund, president and CEO of Exempla Lutheran Medical Center. Please take a moment to go to the Center's Web site if you have not, it's www.centerfortransforminghealthcare.org, to access the complete press kit that includes the news release, storyboards, biographies of our speakers, and other useful background information. I would now like to introduce Dr. Mark Chassin.

Mark Chassin, The Joint Commission: Thank you, Cathy, and welcome to all. Thank you for joining us today to talk a little about the Center for Transforming Health Care's newest project, "Improving Communication During Transitions in Care," a problem that we usually refer to as hand-off communications. First, I'd like to thank the 10 leading hospitals and health systems who volunteered to work with the Center to address this important problem. Exempla Lutheran Medical Center in Colorado; Fairview in
Minnesota; Intermountain in Salt Lake City; Kaiser Permanente/Sunnyside in Oregon; J ohnspensky Hospital; Mayo Clinic; New York Presbyterian; Northshore LIJ Health System; Partners Health Care in Boston; and Stanford Hospital and Clinic in Palo Alto.

As a physician and former hospital administrator, I know firsthand just how serious problems can be when communication between caregivers breaks down. Nowhere is this more evident than in transitions of care. Every patient hand-off unfortunately provides many opportunities for error and that's why the Joint Commission's Center for Transforming Health Care is releasing its second set of solutions, which focus on improving these critical communications during the course of giving health care to patients. This communication between caregivers when responsibilities for patient care is transferred or handed off plays a role in an estimated 80 percent of serious preventable adverse events. It is an ubiquitous problem. Each time a patient moves from one area of care to another; for example, from the emergency department to a medical surgical in-patient unit, from an ICU to an in-patient unit, from a recovery room to an in-patient unit, or from one set of providers to another during a change in shift; those are transitions of care which we informally refer to as hand-offs. Hand-offs are critical because important information about patients’ histories, the exact condition they have, their stability or instability, their treatment; all of that information is needed to appropriately care for the patients and that information can get lost or garbled in transition. One study estimated that in a typical teaching hospital there are 4,000 patient hand-offs every day or 1.6 million per year. When you think about those staggering numbers, you get an idea of how many opportunities there are for miscommunication. So, that there's so many that even a very high percentage of success is really not good
enough. With that 4,000 hand-offs per day number, if 90 percent of them went well, we'd have 400 failures per day. If the percent that went well was 95 percent, we'd still have 200 failures every day. The consequences of these kinds of miscommunications cause serious problems and those problems cause patients to suffer delays in treatment, which can lead to worsening of their conditions, inappropriate treatments which can lead to preventable complications, additional time in the hospital, readmission that could have been avoided, and increased health care cost. In fact, the hospitals participating in this project found that on average more than 37 percent of the time hand-offs were defective and did not allow caregivers who were receiving responsibility for patient care to provide safe and effective care for their patients. The reasons for failures in hand-off communications are many. The 10 hospitals working with the Center on this project found that after months of study and measurement, that, for example, a lack of teamwork and respect between senders and caregivers resulted in situations where critical information about a patient was not communicated. The caregivers that were sending the patient and those receiving had different expectations about what information should be conveyed. The methods for exchanging information, for example, a quick conversation at the patient's bedside often were inadequate to convey all the information that was necessary. Frequently, there wasn't enough time to convey the information. There were distractions, competing priorities, and these failures were happening despite the fact that we have, at The Joint Commission, focused on hand-off communication as a known problem and as a known risk in quality of care, first through a National Patient Safety Goal and now through accreditation standards for many years, and each of the participating hospitals were already devoting significant resources to try
and address these issues. That's why the Center and the hospitals are working together using different and new methods to try to come up with better ways to solve this problem. By systematically measuring and identifying barriers to excellent hand-offs, we can target, test and prove solutions to improve these critical communications. Examples of some of the targeted solutions for competing priorities, for example, were the identification of a client work space setting solely devoted to sharing this information about patients as well as examining the workflow of caregivers to make sure that the hand-off is successful. To solve the problem with inaccurate or incomplete information, hospitals developed and used standardized forms, tools and methods for sharing the information that both senders and receivers wanted to have, making sure that senders and receivers agree on exactly what information is essential to excellent communication. By using solutions targeted to these specific causes of inadequate hand-offs, participating organizations that had fully implemented the solutions achieved an average 52 percent reduction in defective hand-offs. These targeted solutions will continue to be tested at the participating hospitals and, in early 2011, the solutions will be pilot tested in a wide variety of other hospitals of varying sizes and types to prove their effectiveness in these other settings. By mid-year 2011, the Joint Commission Center for Transforming Health Care will have the data to demonstrate the effectiveness of these solutions and whether they can be sustained and specifically will be looking for achieving 90 percent or even greater success rate in completing hand-offs effectively. The solutions will then be added to the Joint Commission's Targeted Solutions Tool™, which now includes solutions for improving hand hygiene compliance. The Targeted Solutions Tool™ is a user-friendly set of tools and guidance that we created for
accredited organizations for them to use without any added cost to measure the extent of their problems, find their causes, and assemble a set of customized solutions that address their own specific barriers to excellent performance. More targeted solutions are coming. In addition to hand-off communications, the Center is aiming to reduce surgical site infections following colorectal surgery through a new project launched this last August in collaboration with the American College of Surgeons. The solutions for that project are targeted for release in the fall of 2011. A project to reduce the risk of wrong site surgery is also in process and its solutions are targeted for release in early 2011. A new project addressing preventable hospitalizations will launch in the coming months. With hand-off communications, with the hand hygiene solutions, and with each of these new projects, we take very important steps forward. There is no silver bullet or quick fix, but together we can make a big difference and begin to transform health care for patients everywhere. Now, I'm very pleased to turn the call over to Dr. Michael Aylward, University of Minnesota assistant professor of medicine and associated with Fairview Health Services. Michael?

**Michael Aylward, Fairview Health Services:** I'd like to thank the Center for shining a light on this critical aspect of patient care which often goes unnoticed. And over the course of this project, we found that hand-offs are a paradox. On one hand, they are simply about two professionals collaborating in the care of a single patient. On the other hand, they are complex involving multiple people under different pressures and constraints who often have to do extra work to make the transitions go smoothly. These workarounds are so ingrained that people have become satisfied with the faulty
process. Through our work with the Center, we've realized that some of the arguments for change in this environment; namely that poor hand-offs lead to redundant work and inefficiencies, decreased productivity, lost opportunities to improve patient care. In the end, good hand-offs are about good teamwork and that is the focus for moving forward. Specifically, at the University of Minnesota Medical Center, we're trying to break down the communication barriers between disciplines to improve teamwork around hand-offs. This will require significant cultural change, but the literature on teams and quality provide an evidence base for these changes. Our vision for hand-offs is one of a shared model between all the patient care providers with critical information formed smoothly among team members as a patient transitions from one part of their experience to another. Thank you.

Michael Dowling, Northshore LIJ Health System: We are delighted to be part of this and I would like to, again, take the opportunity to thank The Joint Commission and Mark Chassin for getting all of the organizations together to focus on this because it does give us all an opportunity to refocus our efforts because we recognize that this is an ongoing effort, as Mark said already. It is, obviously, a big part of a cultural change and we have been very, very fortunate to focus our efforts here in our Children's Hospital and the hand-offs between the emergency room and the in-patient units and the hand-off between the operating room and the post-anesthesia care units and intensive care. And we have seen from the project already that we've had 50 percent reduction in defective hand-offs, which is a major improvement, but we recognize that this is not the end; it's only the beginning. This is where reform really happens. We talk a lot about federal
reform, but quite frankly, these are the types of things that providers have to do on the local level on an ongoing basis if we're ever really going to change and improve the health care of the individuals who come to us for help and that we all have to have a zero tolerance for what's preventable. It is going to require us, as we recognize the disorganization, to enhance our efforts around training, cultural change, use electronic devices more so than we do at the moment, and incorporate hand-off technologies, part of our electronic health record systems, which we're implementing across all of our hospitals, and we also in this project use simulation and Six Sigma methodology to help us achieve the 50 percent reduction. So, we are very, very happy with the progress so far, but obviously recognize that we have a long ways to go. And one of the great benefits of this project is being able to share good practices and experiences with all of the other systems that are involved because it is through the cross-fertilization of ideas and sharing of best practices that we can all continue to get better, which we must. So, we've been delighted to be part of this and the staff is delighted to be part of this because this is one of the areas that the staff, especially the receiving staff who are on the receiving end of the hand-offs often complain about and have complained about, so when they see improvement, it enhances the morale of the staff who are engaged in hand-offs and the transfer of patients and, of course, makes the patient's results better. So, we are delighted with the progress and we are looking forward to the continuation of it and looking forward to putting in place permanent solutions and then being able to transfer those lessons from one of our hospitals, our Children's Hospital, where we did this, to the other 15 hospitals that we have. So, again, I want to say, "thanks" to The Joint Commission and thank all of the other partners who are involved with us on this.
Susan Mullaney, Kaiser Permanente/Sunnyside: Delighted to be with you this morning. This has been an exciting project. It's outstanding. And from the Kaiser Permanente and Sunnyside Medical Center perspective, this is the type of work that we, as administrators, need to be doing and it makes a real difference for our patients. So, it's interesting, on the call you'll hear a lot of us involved in this work talk about how what we did was reset expectations in a mindset within the hospital around what a good hand-off looks like. I think, in aspect of this entire project, we'll reset expectations industry-wide of what we're actually capable of; all 6,000 hospitals in the country are capable of reaching much higher levels of performance and delivering on near perfection for our patients. So, I think that that's the big picture and I really want to thank Mark Chassin for creating the kind of forum that would bring together the leading health care organizations to help prove that case. So, I agree with Dr. Dowling. We've got a long way to go, but we've been really pleased with the progress at Sunnyside. We focused on ED to inpatient unit hand-offs and then in-patient unit hand-offs to skilled nursing facilities. Within the first month of the project and rolling out solutions, we improved our process from ED to inpatient by 50 percent, which is dramatic, and then rolling into month two, we had improved it again another 20 percent, so we're thrilled about that. For us alone, if you think about just that tiny sliver and Mark talked about this in terms of millions of hand-offs a year, for us, just making those improvements in the first two months will set the stage to really make a difference and improve care for over 8,000 people we have coming through our ED a year. So, that's significant. We also saw another interesting by-product of the work in that we've really started to make a
significant impact on reducing the amount of time that a patient has to wait in our ER, which is a very positive thing. It's interesting. In talking to the physicians and nurses involved, the value of this work is that everybody has clear expectations of one another in terms of what a good hand-off should look like and it really focuses people, too, in short time increments. And sometimes the simplicity and obviousness of solutions is what really makes a difference, for us, it has been for physicians and nurses to get really clear on what puts a patient at risk within that first four hours of a patient being transitioned from the ER to an in-patient unit. It might sound obvious to folks outside of the hospital industry, but in the sea of information and stuff that needs to happen when people transition, it really boils it down to that critical point. So, we've seen that it makes a real difference. The other dimension of our participation in this important work is how well do we transition patients from our hospital setting to skilled nursing facilities. Now, this is huge because this is a particularly frail and sick population and a lot can go wrong and typically we deal with institutions and skilled nursing facilities that we contract with and that we might not necessarily own outright. And, as we really focused on what we needed to do in our first month of improvements, we completely eliminated any defects in our process and so that has created a lot of excitement and momentum to keep this work going. And as we look at the tail end of it, so we've really improved how we transition people to that type of setting, we've already started to see a dramatic reduction of readmissions of those patients back to a hospital setting. So, a lot more to come on that. We have a lot of work ahead. Our next step at Sunnyside Medical Center in Portland, Oregon is to make sure that we hardwire this and spread it throughout the hospital and then very quickly work with our 35 other hospitals in our system to spread
this best practice. So, we want to move from testing and solution phases as quickly as possible to hardwiring this throughout the Kaiser Permanente hospital system. So, that's what lies ahead for us in 2011. I want to thank all of my colleagues and the Center for Transforming Health Care for bringing us together this way. I think this is exciting and it's going to set the stage for how we do this type of work in the future. Thank you.

**Kevin Tabb, Stanford Hospital and Clinic:** This has been a tremendously important project at Stanford simply because time and time again we've found that problems with hand-off communication has been at the heart of patient safety and quality issues that have come up in our institution. Almost invariably as we went and did root cause analyses on complications and problems that occurred, we found hand-off communication problems as the central contributing factor in patient safety issues. It was interesting because the partnership between the multiple institutions and with The Joint Commission has been particularly valuable, making sure we all learn from each other, both successes and failures. You've heard many similar themes echoed by different folks on the call and that's interesting because there are a fair number of different types of institutions represented here; large and small, community and academic medical centers. And yet, everybody is facing similar issues. For us, we called this literally, "Getting everybody on the same page." And by everybody, I mean, senders and receivers, physicians and nurses, to level expectations around the type of information that needs to be given to the receivers by senders and making sure that we're all on the same page. Our project was actually one of the few that involved and measured not only nurses and nursing hand-offs, but also physicians; physician-to-
physician and nurse-to-physician. So, in summary, we found the project to be invaluable to better understand the reasons for hand-off problems and to find the best way to improve that in our system. Our next steps include expanding this project beyond the limited areas that we focused on. We focused mainly on ICU to floor transition, so expanding it throughout the hospital and we're already engaged in doing that and also to measure not only sender and receiver satisfaction, but real outcome improvements. We're all convinced that we'll see those things as we expand this project. Thank you.

Grant Wicklund, Exempla Lutheran Medical Center: Lutheran was proud to participate in the program and we felt the initiative was crucial to improve the quality of our hand-off communications, which is for us, too, a significant part of our patient safety issues. We also participated in the inaugural hand hygiene project and our involvement in that project, and this one too, led to improvements in patient safety. The focus on the work for us was in hand-off communications and we wanted to work to standardize the admission process, from the emergency department to the inpatient unit. We know how important it is to communicate accurately and effectively when we transfer patients from one caregiver to another and we, too, needed to understand what was interfering or what could interfere with those communications that would result in patient safety issues. And so we began our project and through the project managed to identify several critical barriers that were affecting communications and they probably are processes that we changed that can be replicated at our other hospitals here in the Denver area and maybe in other places. We believe they'll consistently make patient transfers safer. One of the things that we found during the hand-off process was to
ensure that all the documentation was complete in the EMR when the hand-off occurred, which may seem obvious, but frankly without a clear and defined process, we found that it did not always happen, but it may be assumed to be there. Another significant learning for us was the importance of conducting hand-off communications in the presence of the patient. Involving the patient helped us assure accuracy during the transfer and it really empowered the patients to be able to advocate for their own care and safety, which we feel is important throughout an inpatient stay. Through this, we actually have also decreased wait times. Our complete statistics will not be in until the end of the month, but we've learned a great deal and the hand-off process has been very effective or positively affected by this. We'd like to thank Dr. Chassin for his leadership and we look forward to a continued partnership with the Center and the other hospitals as we divert work to develop and implement solutions to positively affect patient safety and the overall quality of the health care we provide here.

**Cathy Barry-Ipema, The Joint Commission:** Thank you to all of our speakers. We'll now begin the Q&A portion of the news conference. If you wish to ask a question, please state your name and the news organization that you represent. Also, please specify if you have a question directed to a particular person.

**Kevin O'Reilly, American Medical News:** So, how many of the organizations that are participating did "fully implement the solutions?" So, of these 10, how many of them have gotten to that stage? And how are you defining a defective hand-off? And how does that translate to outcomes at this point? Is there any outcome data that you can
report on in terms of this result and if it's medication or whatever? Or a decreased length of stay, mortality or morbidity, or whatever?

**Mark Chassin, The Joint Commission:** The data that are in the press information today and in the storyboards on reductions in defective hand-offs come from five of the 10 hospitals that have fully implemented solutions that they designed to target the problems that they found in their hand-off communication processes. This is a very common finding in these projects that they proceed at somewhat different paces in different organizations. So, we continue to work with all of the organizations. We will be collecting and compiling the data from all of them and updating it on the Web site and update it in future with information that we publish about this project. As I said, the project proceeds at slightly different paces in different places, depending on the nature of the intervention, the nature of the problem, but we expect that very soon many more of the organizations will have the data on their initial implementation and that will be compiled over the coming months. We don't have uniform data on the relationship between the reduction in defective hand-offs and patient outcomes. This is being tracked in somewhat different ways by the organizations that participated. We will certainly be working with them to try to assemble that information. Of course, it's very difficult given the multiple ways in which hand-off communication failures can lead to patient safety problems, but we will be looking to compile ultimate outcome data as we've done with the hand hygiene project. And, I think your third question was about how to define a defective hand-off. That varied somewhat from organization to organization as they tried to line up the expectations of senders and receivers. And the
basic definition of an excellent hand-off was that for critical patient care information, both sender and receiver agreed that the hand-off was effective. We looked at both hand-off as a whole and then at each of the components of it, the sender's perception and the receiver's perception. So, we have a lot of data about each of these hand-offs.

**Michael Dowling, Northshore LIJ Health System:** Given the multiplicity of hand-off situations in the hospital and large health systems, both within hospitals and between hospitals and other facilities in the community, it is important to understand that while we can come up with and The Joint Commission will come up with that, as Mark said, this is an ongoing continuous project and you will be working this for a long time because of the complexity of the situation and the multiplicity of various hand-off situations. So, this is ongoing. I look upon this as a continuous part and adherent core continuous part of our quality effort.

**Tina Irgang, Home Health Line:** I actually had two questions. The first question being: Did any of the participating hospitals or health systems focus on hand-offs between the hospital and home care? And the second question is: Will The Joint Commission use the results from this project to adjust their standards for accredited organizations in any way?

**Mark Chassin, The Joint Commission:** Johns Hopkins did include hand-offs from hospital to pediatric home care as its focus, so there is one example of hand-off to home care. The other question about how these projects affect accreditation standards
is one that we continue to look at for every project that we're doing with the Center. As we get more experience with the dissemination and most effective; we certainly expect that as that information becomes available that it will affect accreditation requirements. We already have an example of that in the first project with hand hygiene. In that, we discovered early on in that project that performance, despite again as in this area, lots of work in hospitals to improve hand hygiene performance, the performance in those participating hospitals at the baseline was under 50 percent; it was 48 percent. And even after a ton of work, they got up to 82 percent. But The Joint Commission's prior expectation when we saw on survey that there were problems with hand hygiene compliance was to require hospitals to provide us data in a rapid turnaround time, that their performance was indeed over 90 percent. Well, we recognize that that was an unrealistic expectation and caused, shall we say, some fancy footwork with respect to that data. So, we changed that expectation to incorporate much more reasonable processes for judging hospitals improving on their hand hygiene compliance. So, this is an ongoing process and, yes, we expect that the results of these projects will affect the accreditation process going forward.

Cheryl Clark, HealthLeaders: Thank you very much for taking my call. I noted that a few of the speakers spoke about culture and respect. Could you please explain to me what you mean by that and how that bears on outcomes and better hand-offs?

Mark Chassin, The Joint Commission: I'll take the first stab and then invite speakers to fill in with details. It is unfortunately not uncommon that the caregivers involved in
sending a patient to the care of another set of caregivers don't really believe that the
time that is necessary to do this process well is something that they ought to be
spending their time on. For example, the documentation that they send with the patient
should be adequate for the receivers to do their job. And, if you haven't actually taken
the time to put receivers and senders in the same room so that they understand each
other's perspectives and needs, then it's easy for one or the other to overlook what
those requirements are and, in the busy course of patient care, the hand-off gets short
shrift. So, recognizing that very often senders and receivers don't work together
routinely as parts of teams and get to know each other, they're very commonly parts of
other teams that don't routinely interact. You can get that kind of siloed view that leads
to barriers to good communication.

**Michael Aylward, Fairview Health Services:** I'd add to that that we've realized that
different people, even within disciplines, so nurses and physicians, have different
pressures and different expectations put on them. So, for example, in the emergency
room, their goals, expectations, pressures are very different from that of people taking
care of a patient at an in-patient service and the talk of culture is acknowledging those
expectations and forming bridges between them to move the patient care forward. And
the reality is the training is actually quite different. So, an emergency room's training is
different than an internal medicine physician's training for an in-patient service and
those two people may not necessarily realize what information is important for the other
party. And so the cultural piece is just an acknowledgement of that and the realization
that checklists and technology are necessary, but not sufficient, to fix this problem.
Susan Mullaney, Kaiser Permanente/Sunnyside: One piece to add to this would be to really emphasize the fact that this project moved teams of people from being myopically focused on their one department and that's easy to do if you work in a busy ER; if you are a busy nurse in a busy inpatient care unit to just get focused on what you need to do in your corner of the world to provide good patient care. So, this has really shifted that sense of what a true team is. A team isn't a team of nurses and physicians in the ER, it goes much broader than that. So, that's what we've tried to create with this work and the respect aspect, that happens on many levels. The receivers in the equation of a hand-off might need to hear or experience that hand-off differently. Each person is slightly different and the senders need to respect the fact that not everybody's going to experience their particular hand-off in the exact same way each and every time. And so it's really shifting in the mindset, too, of that sender, that nurse or physician, giving someone that report and taking the time with the receiver to make sure that they've really had all their questions answered and that they're prepared to receive that patient. Final note on respect is that the organization needs to respect the fact that you need to dedicate the time and effort to this important interaction to have it be done right and I just don't think that we've done that in the past. It takes time to do it right and I think that it manifests in that respect to factor in on that end as well. Thank you.

Kevin O'Reilly, American Medical News: So, are you aiming for one set of solutions, kind of a best practices standard, that other hospitals and doctors can look to implement or is it that people can kind of capture your style, pick and choose what they want to do?
For example, I think Dr. Chassin was saying, we need a quiet space to set aside to do these communications, but someone else was saying we want this hand-off to happen in the patient room and with the patient; I don't know that it's noisy there or whatever. But I don't know if those conflict at all, but it seems to be one example of where there might be a tension between having one standard versus everybody kind of figuring out what works for them and their institution.

**Mark Chassin, The Joint Commission:** That's a really great question and I was going to answer it even if nobody asked it. If you look at the storyboards, you'll see one particular chart that shows a large number of the specific causes of failures of these hand-off communications. And what you'll see is that each hospital that is participating, of the 10 hospitals participating, each of the hospitals has a very different pattern of the causes that were proven to be important in explaining their hand-off communication failures. So, our job, when all of these data are complete and compiled at The Joint Commission, is to create a way through our Targeted Solutions Tool™ or other hospitals, to measure the quality of their hand-offs carefully using the measurement tool developed in this project, figure out what their particular set of important causes is, and then go to the part of the Targeted Solutions Tool™ that allows them to select interventions proven by the original Center hospitals and many other pilot hospitals that we will put together when we have complete data and to enter into the Targeted Solution Tool™. So, they can end up with a customized set of interventions that work to solve the causes that are most critical in their own organization. So, you can think of this as the next generation of best practices. The old style of best practice where we took
something that really worked well in one place and then said to everybody, "Well, do it exactly the same way in your place, " resulted in pretty mediocre results and one of the reasons I think that that's true is this phenomenon that complex problems have many different causes and that these causes differ from one place to another. So, what we have constructed in each of these Center projects is the very systematic approach that this project took to measure carefully, identify the specific causes relevant to each of the participating hospitals and that set of data allows us at The Joint Commission and the Center to compile a list of these frequently occurring causes and then build it into the Targeted Solution Tool™ that is our dissemination vehicle, our primary one now, to thousands of other accredited organizations. The ability to measure carefully, find their causes, and then choose a customized set of interventions from all of the interventions that the participating hospitals developed and proved to work so that they end up with a focused set of interventions that are most effective on the causes that they determine are most important in explaining their failures.

**Michael Dowling, Northshore LIJ Health System:** I would just agree with what Mark said. I completely concur. You cannot have just one very specific template that can be used universally across a broad diverse area as the United States and all the various hospitals and different circumstances because situations do differ from location to location, but the principles and the goals be conscious.

**Cathy Barry-Ipema, The Joint Commission:** We'll conclude today's news conference. I'd like to thank all of our speakers and everyone who joined us. Again,
reporters, if you have any follow-up questions, please contact us at 630-792-5914, and also there will be a playback number of today's call posted online. Thank you to everyone and have a good day.

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