GME Enterprise as Influencer, Hospital Leadership as Driver: A Story of I-PASS Implementation

AiAMC — Alliance of Independent Academic Medical Centers

Annual Meeting Tucson, AZ March 2019

[1]Richard J. Vath MAEd, [1,2]Christopher B. Thomas MD, [1]Academic Clinical Integration Team

[1] Our Lady of the Lake Regional Medical Center, Baton Rouge LA   [2]Louisiana State University Health Sciences Center, New Orleans LA

INTRODUCTION: Background

- Effective transitions-in-care are vital for optimum patient care experiences and outcomes
- Critical exposure to best practices around hand-offs and care transitions happens during a physician's clinical training years
- Hospital operations and clinical learning environment design must be aligned around a shared focus on consistent and accountable processes for care transitions
- We recognized a need for standardizing handoffs across inpatient GME clinical services using the I-PASS framework

References
N Engl J Med 2014;371:1803-12. DOI: 10.1056/NEJMsa1405556

Aim

Prior to July 1, 2017, we set a GME-wide goal for increasing the measurable occurrence of I-PASS hand-offs on all acute care patients on teaching services (via EHR "biopsy") from an unmeasured baseline to 80% by the end of AY18 (June 30, 2018)

METHODS: Intervention

Creating a Shared Need
- GME Leaders and Hospital Quality Leaders approached this intervention with a matching sense of urgency
- Resident and faculty champions were identified and supported with I-PASS curriculum and best practices
- GME supported program faculty in conducting observations of I-PASS handoffs during shift changes.

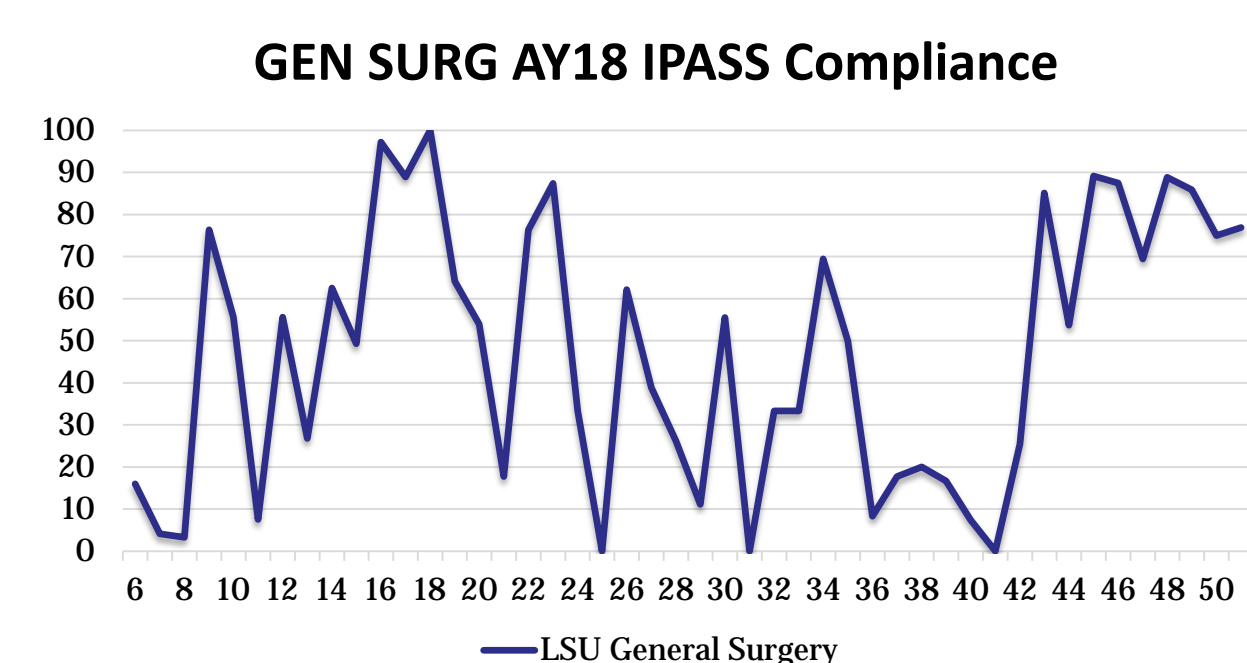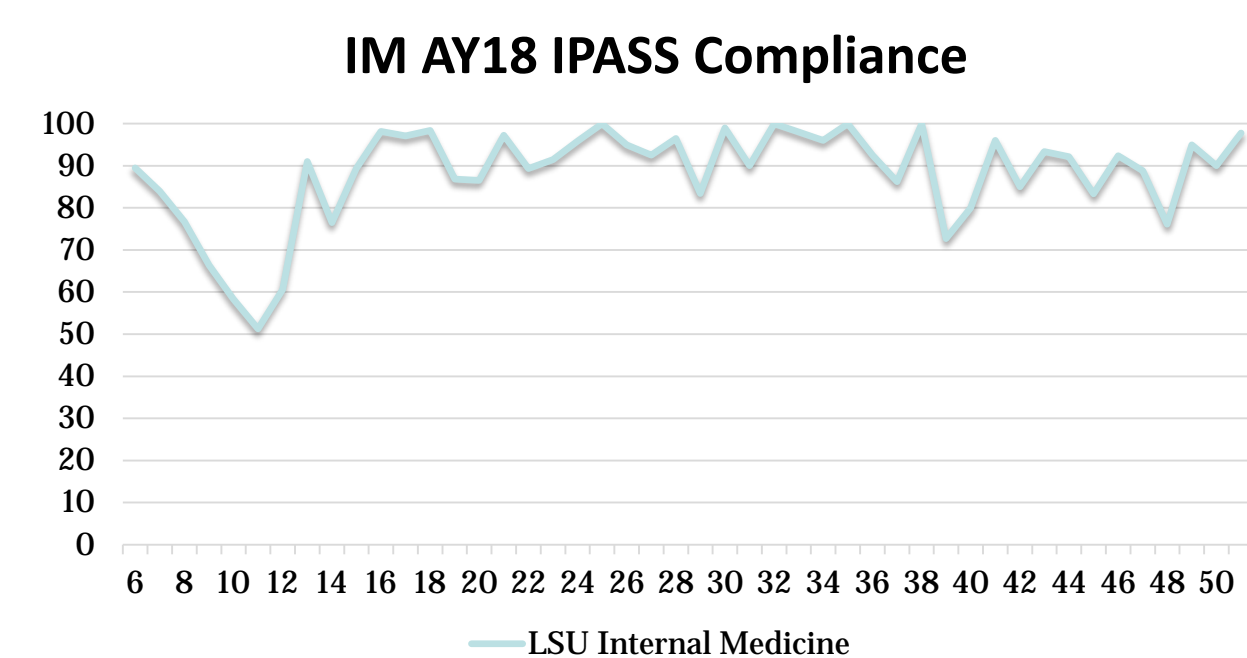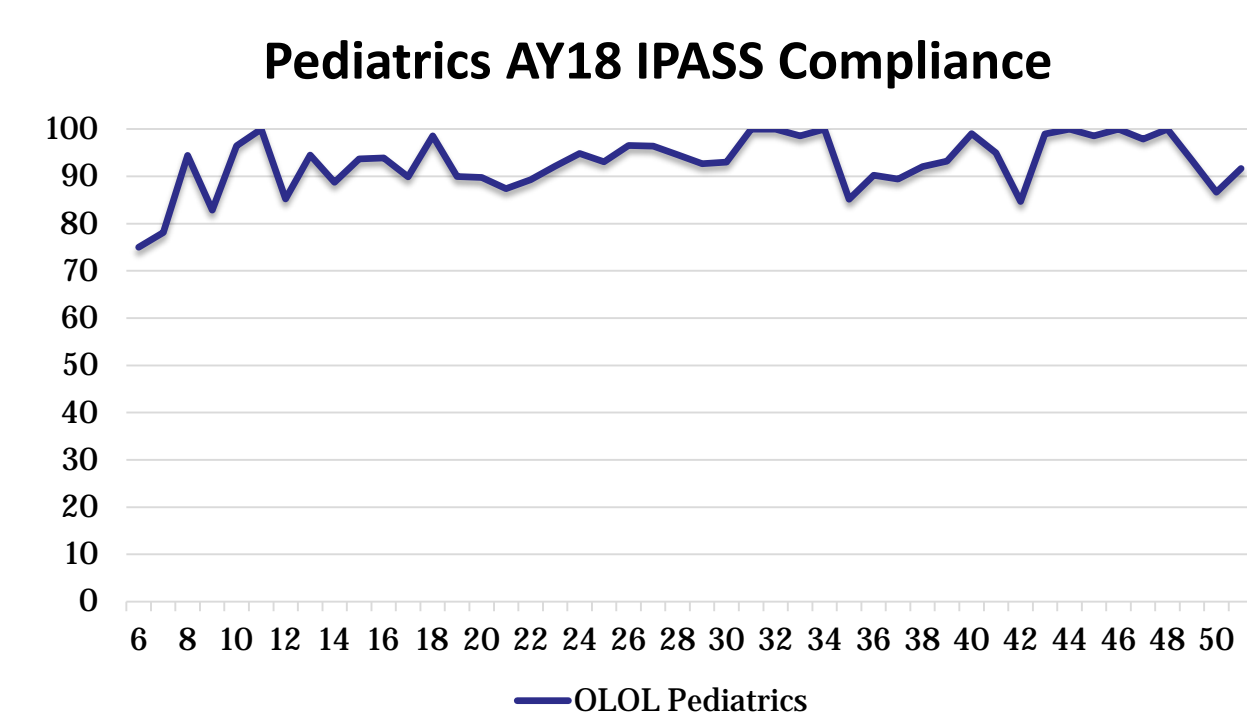**Developing a Surveillance Plan**
- Because handoff records did not persist post discharge, we conducted "biopsies" of the GME teaching team patient lists in the EHR to observe completeness of I-PASS notes
- Percentage "compliance" was determined for all patients, for all teaching services

METHODS: Driving Change

In order to develop a timeline for implementation of I-PASS, GME leadership and Hospital Quality leadership partnered to drive rapid change:
(1) Hospital Quality set timeline for go-live and an _expectation_ of surveillance
(2) GME supported EHR hand-off template optimization and developed a _process_ for surveillance
(3) GME shared surveillance data across programs; Hospital Quality reported data up through hospital leadership

RESULTS

Pediatrics AY18 IPASS Compliance — OLOL Pediatrics

IM AY18 IPASS Compliance — LSU Internal Medicine

GEN SURG AY18 IPASS Compliance — LSU General Surgery

A Story of 3 Programs

1. I-PASS was first adopted within the **Pediatric Program**; instant credibility within the hospital services which drove sustained compliance

2. **Internal Medicine** shifted to I-PASS from an unstructured SBAR framework; Initial adoption was slow, but improved appreciably as data was reported back and competition drove a desire to "keep pace" with Pediatric colleagues

3. **General Surgery** was more challenging and volatile due to practice habits and physician expectations; considerable collaborative work on EHR and processes was required; sustained driving influence of Hospital Quality led to eventual adoption

RESULTS: Continued

OVERALL GME IPASS Compliance in EPIC (7/1/2017-9/18/2018) — GME Overall, FY Goal, FY Stretch Goal
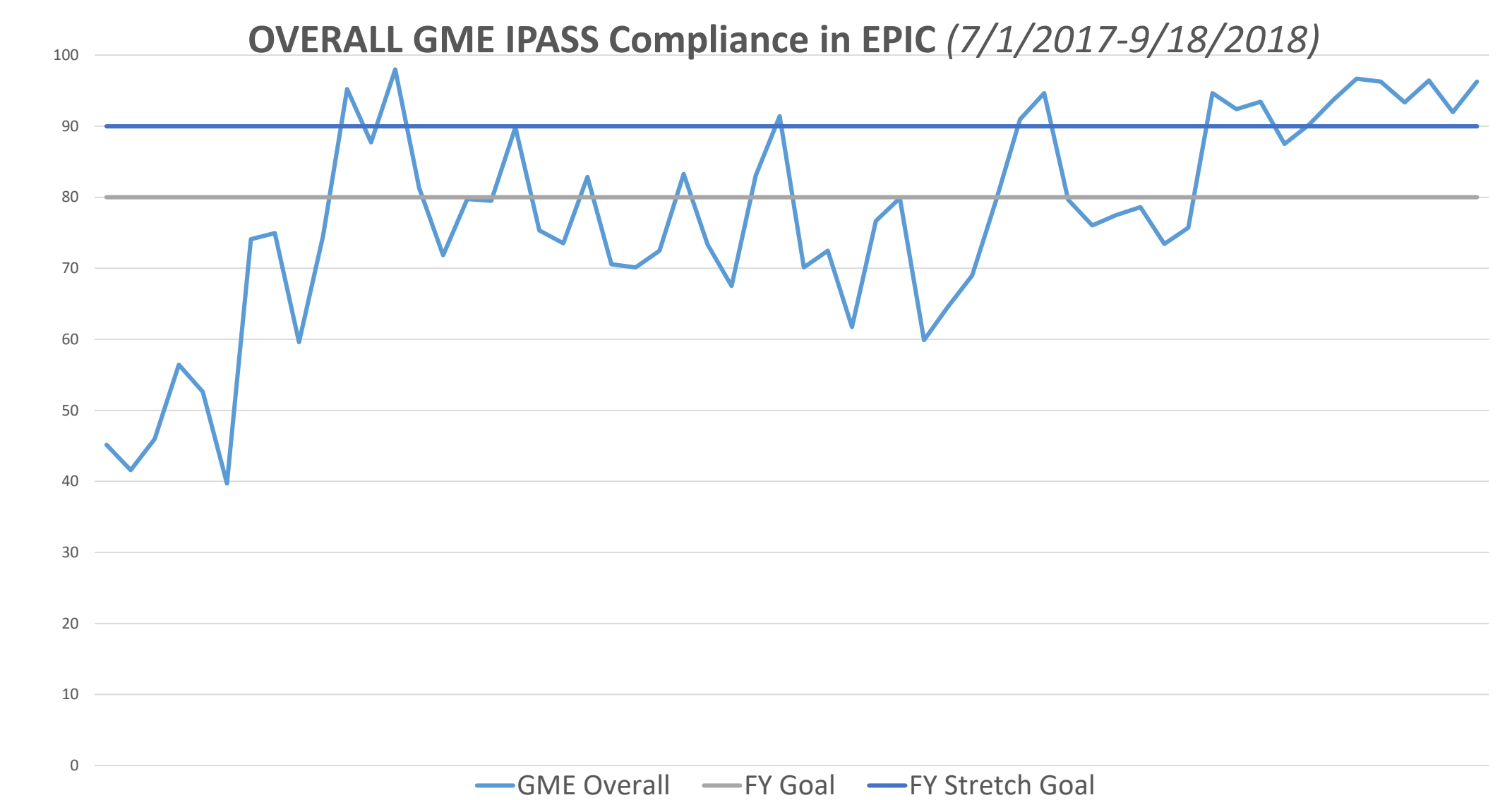
Discussion: Barriers & Strategies

Impact & Lessons Learned
- Sustained data sharing and hospital recognition drove average compliance to above the 90% stretch goal by the end of AY18.
- I-PASS compliance is now shared with hospital medical executive committee and hospital board as part of Quality Reporting
- Follow-up initiatives are underway to develop family-centered and team-based I-PASS processes in GME areas
- _Primary Lesson Learned_: accountability (via hospital directive) + long-term support (via EHR optimization) + positive competition (sharing of compliance data) = steady and sustained change

Limitations
- EHR compliance data is a useful but insufficient proxy for in-person observation of hand-offs. However, it can be utilized to drive positive behavior change

Thank you to the Academic Clinical Integration Team, including:
- Drs. S. Alwood, K. Rhynes, J. LaCombe, M. Roy, M. Bolton, T. Dunbar, T. Demouy
- L. Rabalais, T. Fontenot, A. Hoffman
- Executive Sponsors: L. Calongne, C. Pierce