# Standardized Handoff Implementation at M Health Fairview: I-PASS

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Background: The Joint Commission has identified communication, including handoff communication, as the top root cause of reported sentinel events.1 As such, improving communication between healthcare providers, with patient handoffs, presents an important opportunity to reduce sentinel events. The M Health Fairview System, beginning with the University of Minnesota Medical Center, has begun a system wide role out of utilizing the I-PASS handoff tool, which has been shown to reduce patient handoff errors.1 In this large scale project, there are 3 primary phases including the planning stage, implementation phase, and sustainment phase. Our resident group represents a part within the implementation phase, during which time individual hospital teams are going live with I-PASS across waves.

Objective: Our aim is to reduce the number of adverse patient safety events by reducing errors related to communication. We will achieve this by creating standardized handoffs such that 75% of all handoffs follow the I-PASS structure.

Methods: All MHealth Fairview clinicians at the University of Minnesota Medical CenterWest Bank were assigned interactive I-PASS training prior to the official implementation of I-PASS in the Spring of 2024. Roll out of the I-PASS model, which was integrated into the electronic medical record's handoff tool, was completed in phases amongst various hospital teams. Physicians and advanced practice providers were the first groups to utilize the I-PASS handoff tool, followed by nursing teams. Following these rollouts, members of the I-PASS quality improvement team were trained and completed standardized observations of clinician handoffs in order to assess the utilization, effectiveness, and challenges associated with I-PASS.

Results: Data collection is ongoing. Preliminary data suggest that adherence to the I-PASS mnemonic increased after intervention, but that there is room for further improvement, particularly in reporting illness severity. The data also suggest that perceived patient harm due to poor handoffs has decreased, though analysis is limited by sample size. Due to small sample size and ongoing data collection, statistical analysis was deferred until completion of data collection.

Conclusion: Implementation of a standardized training led to numerically increased compliance of tool utilization, which has previously been shown to reduce adverse patient events.1 The next phase of this study involves rolling out the I-PASS handoff tool within the remaining hospital departments, including the emergency department, as well as at other M Health Fairview community hospital sites. Finally, collecting data on adverse patient events after I-PASS implementation would help to demonstrate whether patient errors are reduced at this institution due to implementation of this standardized handoff tool.

References Joint Commission. (2011). Sentinel Event Statistics Data – Root Causes by Event Type (2004 – Third Quarter 2011) Starmer AJ, Spector ND, West DC, Srivastava R, Sectish TC, Landrigan CP; I-PASS Study Group. Integrating Research, Quality Improvement, and Medical Education for Better Handoffs and Safer Care: Disseminating, Adapting, and Implementing the I-PASS Program. Jt Comm J Qual Patient Saf. 2017 Jul;43(7):319-329. doi: 10.1016/j.jcjq.2017.04.001. Epub 2017 Jun 1. PMID: 28648217. Starmer AJ, Spector ND, O'Toole JK, Bismilla Z, Calaman S, Campos ML, Coffey M, Destino LA, Everhart JL, Goldstein J, Graham DA, Hepps JH, Howell EE, Kuzma N, Maynard G, Melvin P, Patel SJ, Popa A, Rosenbluth G, Schnipper JL, Sectish TC, Srivastava R, West DC, Yu CE, Landrigan CP; I-PASS SHM Mentored Implementation Study Group. Implementation of the I-PASS handoff program in diverse clinical environments: A multicenter prospective effectiveness implementation study. J Hosp Med. 2023 Jan;18(1):5-14. doi: 10.1002/jhm.12979. Epub 2022 Nov 3. PMID: 36326255; PMCID: PMC10964397.