KHC Hospital Improvement Innovation Network

August 22, 2018
10 to 11 a.m. CT

HIIN Goals:
By September 2018, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Agenda

• Introductions and Announcements
• Milestone 8
• Data Update
• Peer-to-Peer Sharing
  2018 Quality Improvement Fellowship Initiatives
  ◦ Falls - Tina Capeder, Anderson County Hospital
  ◦ Readmissions - Tammy Cunningham, Olathe Health System
• Resources & Upcoming Events
Introductions

Special Guests

Tina Capeder, MBA
Director of Quality, Risk and Compliance
Anderson County Hospital

Tammy Cunningham, RN, BSN
Quality and Outcomes Coordinator
Olathe Health System

Betsy Lee
MSPH, BSN, RN
Improvement Advisor
Cynosure Health

KHC Staff

Michele Clark
Program Director
mclark@khconline.org

Eric Cook-Wiens
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Chuck Duffield
Performance Improvement Manager
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Announcements & Updates

- HRET HIIN Progress to Date
- Milestone 8
- HIIN Extension?
- HRET HIIN Sprints
- 2018 HRET HIIN Q.I. Fellowship
- 10th Annual HCP Influenza Immunization Survey

Michele Clark
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Program Director
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HRET HIIN Milestone #8

- All HIIN data are current – October through May*
- Hospitals meet reduction goals in at least 5 topics, preferably 8 or more.

Please help us collectively meet this target;
Ensure your data is current by August 28.

*Being current through June or July is preferred!
HIIN Extension?

- HRET is in negotiations with CMS to extend the Hospital Improvement Innovation Network six months through March 2019.
- CMS also could extend the HIIN another 12 months by exercising its “option year,” continuing through March 2020.
- Join us for September 26 KHC HIIN webinar for an update and overview of the anticipated HIIN extension.

Sprint Summary Webinars

HRET HIIN will be hosting Sprint Summary webinars to review the sprint methodology and participants of sprints will share themes, lessons learned and next steps.

- **ADE Hypoglycemia Sprint Summary Webinar**
  August 24, 2018 | 11:00 a.m. – 12:00 p.m. CT | Register [here](#)

- **CDI Sprint Summary Webinar**
  September 14, 2018 | 11:00 a.m. – 12:00 p.m. CT | Register [here](#)
HRET HIIN Sprints

Kudos to Kansas “sprinters” who participated!

Adverse Drug Events – Hypoglycemia
- Clara Barton Hospital
- Labette Health
- Providence Medical Center
- Saint John Hospital

Adverse Drug Events – c. Difficile
- Newman Regional Health

Adverse Drug Events – Post-Op Sepsis
- Lawrence Memorial Hospital
- Wesley Medical Center

The small Sprint groups of 20-35 hospitals used a chart review discovery tool to identify opportunities to improve, create an aim statement, and begin to test changes to improve patient care.

2018 HRET HIIN Q.I. Fellowship

Congratulations to our 2018 Kansas Fellows!

- Tina Capeder, Anderson County Hospital
- Tammy Cunningham, Olathe Health System
- Verla Friesen, Mercy Hospital, Inc.
- Kristen Hadley, Osborne County Memorial Hospital
- Courtney Huhn, VA Eastern Kansas Healthcare System
- Ester Knoblock, Newman Regional Health
- Sarah Lueger, VA Eastern Kansas Healthcare System
- Dorothy Rice, Ransom Memorial Hospital
- Katherine Rucker, Olathe Health System
- Michelle Toogood, Memorial Health System
- Tiffany Trapp, Rush County Memorial Hospital
- Lee Vannier, VA Eastern Kansas Healthcare System
- Jamie Waggoner, Ashland Health Center
10th Annual Hospital HCP Influenza Immunization Survey

Survey link has been distributed to designated hospital contacts to assess 2017-18 HCP immunization rates and key strategies. **Please respond by 8/31/18.**

Link to online HCP Influenza Immunization toolkit: [https://www.khconline.org/initiatives/health-care-personnel-influenza-immunization](https://www.khconline.org/initiatives/health-care-personnel-influenza-immunization)

KHC HIIN Data and Progress Update

- Data cleanup and schedule for Milestone 8
- KHC HIIN Progress to Date
- Focus Area Highlights
- Data submission schedule

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Data and Measurement Director
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Data Cleanup for Milestone 8

- HRET provides KHC with a list of potentially incorrect data points
  - If you received an email from Michele, please let us know if data are correct.
  - If not correct, please update the originating database with corrected data (QHi or NHSN)
  - Please make corrections by: **Next Tuesday 8/28/2018**

Data Schedule for August

- **8/18/2018** Data snapshot for today’s data
- **8/23/2018 (tentative)** Data snapshot for preliminary report
- **Friday 8/24** Send preliminary reports to hospitals
- **Tuesday 8/28** Last day to clean up data
- **Wednesday 8/29** Data snapshots for final report
- **Friday 8/31** Final reports, Milestone 8 data is finalized
Current Progress (as of 8/18/18)

Harms per 1,000 Discharges

- 26% improvement in total harm (most recent month compared to baseline)
- 2,338 harms prevented
- 199 lives saved

Improvement Year-to-Date

HRET HIIN Improvement Calculator v5.3 on 08/18/2018
Focus Area Highlights

- Readmissions
- Falls with Injury

Preliminary Results

Readmissions

- Baseline: 8.1%
- Project-to-date: 7.8%
- 3.6% reduction
Preliminary Results

Falls with Injury

- Baseline: 1.05 per 1000 patient days
- Project-to-date: 1.26 per 1000 patient days

Focus Area Highlights

Kansas HIIN Data Submission Schedule

<table>
<thead>
<tr>
<th>Outcome &amp; Process Measures for HACs occurring in:</th>
<th>Readmissions for index discharges in, and SSI for procedures performed in:</th>
<th>Submission Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>March, 2018</td>
<td>February, 2018</td>
<td>April 30, 2018</td>
</tr>
<tr>
<td>April, 2018</td>
<td>March, 2018</td>
<td>May 31, 2018</td>
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<tr>
<td>May, 2018</td>
<td>April, 2018</td>
<td>June 30, 2018</td>
</tr>
<tr>
<td>June, 2018</td>
<td>May, 2018</td>
<td>July 31, 2018</td>
</tr>
<tr>
<td>July, 2018</td>
<td>June, 2018</td>
<td>August 31, 2018</td>
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<td>August, 2018</td>
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<td>October, 2018</td>
<td>December, 2018</td>
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<tr>
<td>December, 2018</td>
<td>November, 2018</td>
<td>January, 2018</td>
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</tbody>
</table>
Two tracks with Institute for Healthcare faculty offering QI training to kick-start and support projects related to the HIIN goals

Offered from January to July 2018. Featured interactive webinars and online courses on key topics in quality improvement. Simultaneous to the webinars and coursework, Fellows apply their learning by either developing or advancing a project to improve outcomes in their own department or unit.

Multiple Fellows were encouraged to participate from one organization. They may work as a team on a project, or individually.

IHI Open School subscription was provided at no cost to each fellow. Online modules supported learning the Model of Improvement.

www.hret-hiin.org/fellowships/qifellowship/
Five practical strategies for managing improvement projects

- Frontload the Work
- Build the Team
- Create and Keep Pace
- Make It Easy
- Start with the End in Mind

2018 FELLOWSHIP PROJECT

Prevention of Falls with Injury Long Term Care Unit (RLC)

Tina Capeder, MBA
tcapeder@saint-lukes.org
Anderson County Hospital, Garnett, Kansas

Fellowship Track (Accelerating Improvement)
AIM AND BACKGROUND

Aim
Reduce the number of preventable falls organization-wide from 57.9% to 45.6% by December 31, 2018.

Background
Among older adults (those 65 or older), falls are the leading cause of injury-related death (CDC). Fall-related injuries decrease the resident’s quality of life and ability to function. Falls for residents who fall without injury often develop a fear of falling that leads to self-imposed limitation of activity. Soft tissue injuries or minor fractures can also cause significant functional impairment, pain, and stress. Even “minor” falls can prompt the older person to fear falling, causing him/her to limit activity, resulting in loss of strength and independence. One in every 10 residents who fall has a serious related injury and about 65,000 residents suffer a hip fracture each year.

Driver Diagram

Primary Drivers
- Recognition & Assessment of Risk
- Plan to address risk of falls
- Act to reduce risk of falls
- Review and monitor

Secondary Drivers
- Develop an individual care plan with individual identification of risk factors
- Review risk assessment within 24 hours of admission
- Review risk assessment with resident and family/caregiver
- Provide information about fall prevention
- Appropriate referrals for special assessments or interventions

Communicative
- Education
- Staffing
- Intervention Planning
- Resident, family, and caregiver involvement

- Full risk assessment completed monthly or if condition changes
- Conduct ongoing measurements including new medication orders (sedatives, sleep aids, antipsychotics)
- Assess the possibility of minimizing personal alarms
- Create a safe environment by eliminating hazards
- When a fall occurs, complete fall huddle after the fall with staff working and review following more with fall huddle team.
**Measure: Outcome**

- Reviewed falls for 2017 by category, per hallway, time of day and day of week to determine where to begin to focus our improvement plan.

**Category of Falls**

![](Category_of_Falls.png)

**Time of Day**

![](Time_of_Day.png)

**Measure: Process**

- Utilize the Plan Do Check Act (PDCA) in performance improvement process.

- Selected a team comprised
  - Management of nursing home
  - Staff of nursing home
  - Pharmacy
  - Rehab
  - Hospitality
  - Quality
  - Risk

- Current state of falls in the nursing home:
  - Fall Rate for 57.9% based on the
    - Composite Score Report Long-Stay Quality Measure Performance dated October 2016 to October 2017
    - 7.9% score of falls with major injury.
Measure: Process

- The team then looked at the root causes:
  - Why? Falls occur on the south hallway – bigger more rooms, more residents, staffing
  - Why? Residents and Families not provided education
  - Why? Staff not provided training on how to prevent falls with injury
  - Why? Sit to stand not working well
  - Why? Staffing (e.g. only one float, not enough aides)
- In addition, the team looked at the need for performing fall huddles

Measure: Balance

- Measured the incident reporting
- Measured monthly risk assessments
- Measured the effectiveness of the fall huddles
- Provided feedback and education for staffing
Change Ideas

<table>
<thead>
<tr>
<th>Item No.</th>
<th>What</th>
<th>Who</th>
<th>When</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Educate residents and families on how to prevent injury if they are going to fall and encourage mobility to the residents and families to prevent further falls – falls safety brochure for admission</td>
<td>Dee Dunn, Tina Capeder</td>
<td>August 2018</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Implement fall huddle team – to include rehab, nursing and hospitality along with the RLC staff – meet weekly (review fall huddle for complete and send to risk management)</td>
<td>Dee Dunn, Tabitha Clark</td>
<td>July 2018</td>
<td>Completed and Ongoing</td>
</tr>
<tr>
<td>3</td>
<td>Involving Therapy for it to stand and provide education to staff group setting resident education</td>
<td>Ryan Meyer</td>
<td>August 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>4</td>
<td>Educate staff what is a fall to heighten awareness to respond quickly to alarms</td>
<td>Margaret Donnelly, Dee Dunn, Tabitha Clark</td>
<td>April 2018</td>
<td>Completed and Ongoing</td>
</tr>
<tr>
<td>5</td>
<td>Revise System policy to support LTCU Implement Policy and send to Policy Committee</td>
<td>Margaret Donnelly, Tabitha Clark</td>
<td>May 2018, August 2018</td>
<td>Completed, In Process</td>
</tr>
<tr>
<td></td>
<td>Educate Staff</td>
<td>Dee Dunn, Tabitha Clark</td>
<td>August 2018</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Improve call light system to track time to answer call light/alarms (new chair/bed alarms hooked up to the call system in January 2018)</td>
<td>Sara Roecker, Katie Jensen</td>
<td>January 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>7</td>
<td>Add 4th aide on the floor, add 2 floats throughout the home, added med aid shift 2-1030p to free up RN</td>
<td>Margaret Donnelly, Katie Jensen</td>
<td>March 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>8</td>
<td>Discuss changes in 1010 LTCU (as of June 2018, called IDT)</td>
<td>Margaret Donnelly, Dee Dunn, Tabitha Clark</td>
<td>August 2018</td>
<td>Completed and Ongoing</td>
</tr>
</tbody>
</table>

Current State Comparison
Reflections

• **Barriers encountered:**
  – No barriers
  – We had buy in for this improvement initiative from management to staff and supporting departments

• **Lessons learned:**
  – *Education and communication* is key to improvement not only for the staff but also for the residents and family.
  – *Understanding the state of where we are in preventing harm* to our residents is vital to the success of quality of life.
Next Steps

• **How will you sustain improvements made?**
  – Continue to monitor quarterly
  – Report to staff during monthly staff meetings
  – Add to quality assurance performance improvement committee

• **How and where will you spread the successful ideas?**
  – Spread the successful ideas to our hospital medical / surgical unit and swingbed

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Questions for Tina?
AIM AND BACKGROUND

**Aim**
- To reduce 30-day, all-cause readmissions at Olathe Medical Center by 50% by December 31, 2018.

**Background**
Olathe Medical Center has had borderline 30-day all-cause readmission rates. In 2017 we were penalized by CMS for risk-adjusted readmission rates that were above the benchmark. It was at this time our hospital decided to look closer at readmissions and find ways to reduce them.
To reduce 30-day, all-cause readmissions at Olathe Medical Center by 50% by December 31, 2018.

- **Determine who is at high risk for readmission**
  - Collect information through abstraction
  - Use risk stratification tool to identify patients at high risk
  - Initiate high risk for readmission IPOC

- **Improve coordination of care**
  - Develop TDC forms in EMR that are shared across continuum
  - Schedule follow-up appointments prior to discharge
  - Medication reconciliation at each transition of care (TOC)

- **Personalized disease management and patient education**
  - Create patient and caregiver accountability
  - Identify readmission drivers through patient interviews
  - Educate patient on disease; what to do when symptoms worsen
  - Provide accurate med information at discharge

**Measure: Outcome**

- I looked at the overall percentage rate of 30-day, all-cause readmissions utilizing Kauffman Hall/PEAK data for hospital readmission rates. These numbers are based on claims data. Because of this, the data is usually 30-45 days delayed.
Measure: Process

Through chart abstraction, I looked at:

- Was the High Risk for Readmission Individualized Plan of Care (IPOC) initiated for LACE score > 12?
- Were follow-up appointments scheduled prior to discharge?
- Did patients attend follow-up appointments?
- Were community resource needs set-up and utilized by the patient when discharged?
- Was a medication reconciliation completed on admission and was it correct at discharge?

Measure: Balance

Unanticipated consequences included:

- Improved patient satisfaction scores when their education needs are better individualized. These are currently measured by our HCAHPS scores.
- Patient frustration with multiple follow-up phone calls after discharge. This is measured by patient complaints made to our Case Managers and Care Coordinators.
Change Ideas

- Development of Discharge Transition of Care bands in the EMR
- Improved initiation of the High Risk for Readmission IPOC on appropriate patients.
- Schedule follow-up appointments prior to discharge home.

Run Chart

30-Day, All-Cause Readmissions

- AMI Navigator making follow-up phone calls
- Care Collaboration Meeting
- Began chart abstraction

Patient Readmission Percentage

- Percentage
- Goal
- Median

Time

Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17, Oct-17, Nov-17, Dec-17, Jan-18, Feb-18, Mar-18

0.00% 2.00% 4.00% 6.00% 8.00% 10.00% 12.00% 14.00% 16.00% 18.00% 20.00%
Reflections

• Lessons learned:
  – It was more difficult to get buy-in than I anticipated. Although everyone wants improved care for our patients, people are reluctant to change. I also learned that IT holds a lot of power!

• Barriers encountered:
  – One barrier was trying to implement a “boomerang” icon on our ECC tracker board. Although the staff nurses liked the idea of being able to identify patients who were potential readmits, the ECC physicians were not impressed.
  – Our biggest barrier is trying to get our new Discharge Transition of Care bands put into the EMR. These bands are a way for inpatient Case Managers and outpatient Care Coordinators to document their communications with the patients, and see each other’s documentation. We have them built, but are having difficulty with our IT department putting them in the EMR due to a “freeze.”

Reflections Cont.

What is your plan for overcoming barriers (or how you did):

❖ Our IT department has been on a “freeze” due to Revenue Cycle. Revenue Cycle went live on June 1, 2018. We have submitted a change control request to have our Discharge Transition of Care bands put into the EMR, so I will continue to push the IT department for this. Readmissions not only negatively affect quality patient care and satisfaction, certain CMS diagnosis can cause our hospital to be penalized again if not corrected or reduced. Because of the potential loss to the hospital, I am getting leadership buy-in and support to quickly get this put in the EMR.
Next Steps

How will you support spread and sustainability?

- I plan to develop a patient interview tool to interview patients who are readmitted within 30 days. The purpose of this is to collect data and find out what the readmission drivers are for these patients once discharged. I would like to interview 10 patients/month for one quarter and see if there are any commonalities.
- I am working with our Cardiology/Chest Pain PI team to reduce readmissions post-AMI. We would like to improve scheduling follow-up visits prior to discharge, focusing on AMI patients who have developed decreased LVEF after their AMI event. The goal is to have these patients seen within 3-5 days after discharge. I will help with data abstraction.
- I will be co-facilitating a Medication Reconciliation PI Team. There used to be one at this facility years ago, but it quit meeting once the issue of medication reconciliation appeared resolved. Medication reconciliation is vital to reducing readmissions.

Questions for Tammy?
Resources and Upcoming Events

- IHI Open School
- Why I’m HIIN
- Sepsis Awareness Month
- Fall Prevention Day
- Antibiotic Awareness Week
- Upcoming Learning Events
- Wrap Up
- Contact Us

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Limited availability!

The AHA/HRET HIIN is now extending unused IHI Open School tickets to all HRET HIIN hospitals.

This offer is on a first-come, first-serve basis and the free subscriptions to this IHI learning management system are valid until 12/31/2018.

Download the instructions in the webinar pod below or visit
#WhyImHIIN

Share your team’s passion for its work:

1) Download PDF:  
   [http://gg.gg/WhyImHIIN](http://gg.gg/WhyImHIIN)

2) Print, fill out with bold marker.

3) Post with hashtag  
   #WhyImHIIN

See Kansas and more Selfie Statements on HRET HIIN website at  

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New HRET HIIN Change Packages  
*to be released this fall*

- Psych & Rehab
  - Focus: Identification of leading practices to improve psych and rehabilitation hospitals
  - In collaboration with Technical Advisory Councils

- Diagnostic Error
  - Focus: Reducing Harm from Diagnostic Error
  - In collaboration with [Society to Improve Diagnosis in Medicine](http://www.society.com)
Sepsis Awareness Month

- When: All of September
- Resources and posts ready to share at: sepsisawarenessmonth.org

Fall Prevention Awareness Day

- When: September 22
- Resources and posts ready to share at: ncoa.org/healthy-aging/falls-prevention
Use Antibiotics Wisely Week

- When: November 12 - 18, 2018
- Resources and posts to share at: UseAntibioticsWisely.org
  Or contact KHC for more info.

Upcoming Webinars

HRET HIIN: Q.I. Fellowship Office Hours
August 22 ● 11:00am - 12:00pm
Register here:
http://hret.adobeconnect.com/qi-fellowship-20180822/event/registration.html

HRET HIIN: ADE Hypoglycemia Sprint Summary Webinar
August 24 ● 11:00am - 12:00pm
Register here:
http://hret.adobeconnect.com/ade-20180824/event/registration.html

HRET HIIN: Culture of Safety Event | Workplace Violence
August 27 ● 11:00 a.m. to 12:00 p.m.
Register here:

All times listed are Central Time.
Upcoming Webinars

HRET HIIN: The Importance of “F”: Family Engagement and Empowerment in VAEs
August 30 ● 11:00am - 12:00pm
Register here: http://hret.adobeconnect.com/vae-20180830/event/registration.html

Great Plains QIN: Improving Adult Immunizations and the Importance of Healthcare Worker Immunization
August 30 ● 12:00 - 1:00pm
Register here: bit.ly083018IMM

HRET HIIN: Guidelines for Opioid Use in the E.D.
August 30 ● 2:00 - 3:00pm
Register here: http://hret.adobeconnect.com/e5ymwp97clzv/event/registration.html

Upcoming Webinars

HRET HIIN: Diagnostic Error Change Package
September 11 ● 11:00am - 12:00pm
Register here: http://hret.adobeconnect.com/diagnostic-error-20180911/event/registration.html

HRET HIIN: C. difficile Sprint Summary Webinar
September 14 ● 11:00am - 12:00pm
Register here: http://hret.adobeconnect.com/cdi-20180914/event/registration.html

KHC HIIN: Monthly Virtual Meeting
September 26 ● 10:00 – 11:00 pm
Anticipated topics to include: HIIN Extension
Register here: https://khconline.adobeconnect.com/khc-hin-09-26-18/event/registration.html
Please provide feedback to this webinar
Let us know your next steps.

https://www.surveymonkey.com/r/KHC-HIIN-082218
Your HIIN Contacts

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