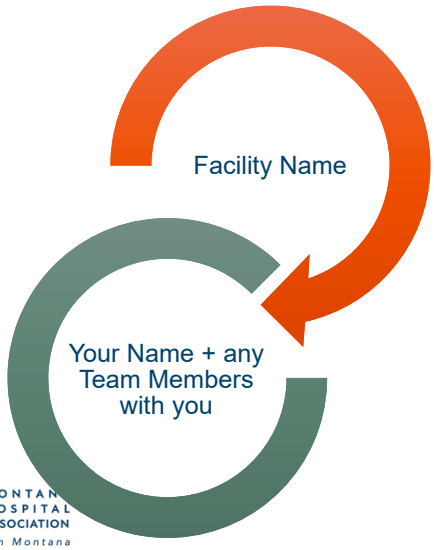
Cultivating Roots of Quality Improvement

Session 8:
Celebration & Sharing
August 3, 2022

Chat Box Roll Call



- Cabinet Peaks Medical Center
- Central Montana Medical Center
- Community Hospital Of Anaconda
- Fallon Medical Complex
- Frances Mahon Deaconess Hospital
- Holy Rosary Health Care
- Missouri River Medical Center
- St. Luke Community Hospital

Stories from our Hospitals

- Cabinet Peaks Medical Center
- Central Montana Medical Center
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- Frances Mahon Deaconess Hospital
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Cabinet Peaks Medical Center
Libby, MT

PLAN

Background: Why did you choose this project?

Each day the indwelling urinary catheter remains in place, the risk of urinary infection (CAUTI) increases. The need for a catheter should be monitored daily and should only be inserted when necessary/indicated (and left in place only as long as necessary). Indwelling catheters are not indicated for incontinence, immobility, obtaining urine specimens, close monitoring of urine output in non-critical patients, or patient request/convenience. Hence our question – "WTF" (WHY the Foley?)

Project Aim: What is your goal and how will it be measured?

Our goal is to reduce urinary catheter placement in patients who do not meet criteria by September 30, 2022. We will accomplish this goal by analyzing the "WTF" data obtained from the nightshift Charge RNs and cross-referencing the CPMC Indwelling Catheter policy. This information will be conveyed to the Acute Care staff members and hospitalists/providers, alongside educational materials and a policy "refresher". Accomplishing this goal will result in lower risk of CAUTI infections and a decrease in patient safety issues/concerns.

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DO

What did you do to make a change?

Starting with the Night Charge RNs who tally "patient days" and "device days", we added a column to indicate "WTF" (WHY the Foley?). From this information, we can identify whether or not catheters are being inserted ONLY when necessary - or if more staff/provider education is necessary to understand when NOT to insert a Foley. Having the nursing staff help in uncovering the WHY helps them think critically, ask pertinent questions, and feel like part of the solution to a problem.

Change will be known when our indications for Foley catheters match our designated policy indications.

Our monthly surveillance data will alert us to any CAUTI infections, and we will use those instances as a learning tool, as well.

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STUDY

	BASELINE VALUE	*Baseline Date*	REMEASURE VALUE	*Remeasure Date*	Did you improve?
% of Foleys inserted without proper indication (based on Night Charge RN "WTF" data)	**80%** (4/5)	*7/1/22*		*8/1/22*	

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
It was remarkably eye-opening! Out of the 5 observations in June, 4 of them could potentially be non-indicators for catheter placement to begin with! This highlighted the need for EDUCATION - education to our staff, and education to our PATIENTS.

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ACT

Adopt, Adapt, or Abandon?	Adopt/Adapt
Changes to be made?	*We have started PDSA Cycle 2 with the hope that we will have more data to analyze and create a larger picture of what Foley catheter insertion looks like at OUR facility. Having that type of data to bring to physicians and hospitalists will be more meaningful when it comes to creating change. Our Medicine Committee and Infectious Diseases Committee hold meetings in mid-August and this information will be presented for review/thoughts/next steps.*
Lessons Learned?	Staff education is HUGE.
Next steps or future goals?	Nurse-driven protocol for Foley catheter removal
Conclusion	Although our CAUTI infection rates remain extremely low, there is always room for improvement!

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Project Team Acknowledgements

- Nichole Hollingsworth, Quality Program Specialist
- Lacey Poirier, RN, BSN, Infection Prevention/Education
- Bethany Ramsey, Night Charge RN

Cabinet Peaks Medical Center

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Central Montana Medical Center

PLAN

Background: Why did you choose this project?

Medication history review is crucial for providing safe patient care. An accurate medication list contributes to a decrease in medication errors, readmissions and adverse events. Knowing what the patient is currently taking, how they are taking it, and what is/isn't working is so important when developing a plan of care. The current issues at CMMC include a lack of knowledge by staff on how to accurately document a medication history with our new electronic health record (EHR), roles not clearly outlined of who is responsible for this history, and the transferring of an accurate medication history to different types of encounters within our EHR (Emergency Department, Observation, Inpatient, etc.).

Project Aim: What is your goal and how will it be measured?

Our goal is to develop a process for medication history review to occur at all clinical encounters that take place within CMMC, with a focus on Inpatient encounters this year. We would like to see medication history review completed in at least 80% of Inpatient encounters.

A reporting platform will be used to gather compliance data by department. Pharmacy staff will be the main resource for educating clinical staff.

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DO

What did you do to make a change?

A meeting was held with CMMC providers to determine the best process for medication history review and which roles should be assigned to nursing versus providers. Education was completed by a clinical pharmacist to clinical staff on completion and documentation of an accurate medication history. Continuous monitoring of medication history compliance was assigned to the Quality Department and monthly reports were sent to applicable department managers to share with their clinical staff. Re-education to be completed as necessary and new employees to receive medication history education at orientation.

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STUDY

	BASELINE VALUE	*Baseline Date*	REMEASURE VALUE	*Remeasure Date*	Did you improve?
Medication History Compliance (Inpatient)	34%	*May 2022*	59%	*June 2022*	Yes, by 25%

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
Education completed for clinical staff as planned. Medication history compliance improved from 34% in May to 59% in June. Continuous education moving forward.

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ACT

Adopt, Adapt, or Abandon?	Adapt
Changes to be made?	Next PDSA cycle to be completed with a focus on provider education rather than nursing.
Lessons Learned?	Closely schedule education sessions for both roles.
Next steps or future goals?	Develop a consistent process for medication history review to occur at *all* clinical encounters that take place within CMMC. Once the process is adopted with Inpatient encounters, it will be utilized within Outpatient services as well.
Conclusion	Nursing and providers must clearly understand their roles and how their teamwork can result in accurate completion of both the mediation history and medication reconciliation for the patient.

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Project Acknowledgements

- Amber Yaeger, Clinical Pharmacist
- Kristy Heller, Quality Improvement Manager
- Esther Bradley, Quality Analyst
- Lexie Jelinek, Quality Improvement RN

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COMMUNITY HOSPITAL OF ANACONDA

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Community Hospital of Anaconda

PLAN

Background: Why did you choose this project?

Improve patient awareness of all their medication indications; new as well as prior to admission (PTA) regardless of medication class

Project Aim: What is your goal and how will it be measured?

Improve Care Transitions domain for (HCAHPS)with an increased focus on Patients Understanding of taking Medications. Goal is a 5% increase by September 2022.

DO

What did you do to make a change?

4/25/22 Formally established QI Roots Committee
- *Teamwork exercise brought forth ideas to focus on*

5/2/22 Formulated a very hearty goal 3 prong approach
- *Inpatient; daily pharmacy education with the patient on all medications & indications & manually recording on to the future After Visit Summary (AVS)*
- *Discharge process; nurse managers use teach back with all parts of the AVS to include PTA as well as new medications' indications*
- *Wrap around support from the ambulatory side; Primary Care Provider need to initiate "via input" into E.H.R system the indications and or Diagnosis at the ordering level for all medications*

5/11/22 Revision of focus and goal. Broad goal of Care Transitions changed to Pt Understanding of taking medications
6/27/22 Continue to work with EHR as well as set a small goal: 4 patients in 4 weeks to have PTA medications associated with indications
7/05/22 Met with EHR Executive Director of Medical Clinical Informatics for guidance on ambulatory workflow improvement.
7/26/22 Addition to the team and coordinated first meeting with Champion Ambulatory Care staff member to visual EHR workflows

STUDY

	BASELINE VALUE	Baseline Date	REMEASURE VALUE	Remeasure Date	Did you improve?
AVS has indications on all medications at discharge	0%	*May 1, 2022*	60%	*June 16, 2022*	Yes 60%
Indications on PTA medication orders – in hopes not requiring reentry of data each AVS print	0%	July 1, 2022	Pending	Pending	Pending
HCAHPS – Care Transition Patient Understanding of Taking Medications	51.4%	April 2022	60.7%	June 2022	Yes >8%

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

**With pharmacy's due diligence a 60% improvement rate was noted within a month showing indications on the AVS for medications - this may or may not be sustainable given the time restraints and consuming nature this task requires*
**Great appreciation and the necessity was voiced with each nurse – patient discharge interaction*
**CHA Leadership continues to attempt to get our EHR vendor to hear the significance of this project and the impact a more user-friendly hard stop would improve a multi century old problem (hidden medication indications resulting in noncompliance and patient misunderstanding has been documented since 1833 NEJM.org July 28, 2016)*

COMMUNITY HOSPITAL OF ANACONDA

ACT

Adopt, Adapt, or Abandon?	Pharmacy continues with updating AVS with every discharge Our EHR build does not allow revision of PTA meds without initiating a new order, therefore, Ambulatory Services will initiate placement of indications; to new ordered medication in the clinic setting, medications that are refilled, and all medication orders for new clients. This will be a work in process- education to go out in weekly meetings, a few set staff have been picked to initiate process; starting with new providers, new nurses, and two nurses that have done this process in prior work history focus on Family Practice at this time
Changes to be made?	Processes to come to help our Ambulatory/Clinic Staff to learn to implement "input of indications for all medications"
Lessons Learned?	Bedside manner and time with patients may not be directly measurable – yet those are the unmeasurable positive outcomes that keep us here
Next steps or future goals?	Continue to work with our EHR vendor and system to produce the most effective system for our patients
Conclusion	Overall a slight improvement has been noted in both the Care Transitions domain (HCAHPS) and focused question, Patient's understanding of taking medications.

COMMUNITY HOSPITAL OF ANACONDA

Project Acknowledgements

- Jamie Johnson Chief Nursing Officer
- Mary Pat Ford Chief Operations Officer
- Amy Reisenauer Assist. Director of Nursing
- Halli Perala Clinic Administrator
- Ty Tyvand Pharmacy Director
- Lisa Laslovich Pharmacist
- Kelly Skocilich UR/IC/Employee Health RN
- Sue Kaasch Social Services Director
- Jessie Crawshaw Nurse Manager
- Kristen Villa Nurse Manager
- Riley Vetter Pharmacist
- Sherrie Patterson ACO, CCM Care Coordinator
- Kathryn Hall Social Services
- Kristi Danforth Clinical Review Analyst
- Judy Wonnacott Ambulatory Services Champion

Central Montana Medical Center

PLAN

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DO

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FRANCES MAHON
DEACONESS HOSPITAL

PLAN

Background: Why did you choose this project?

Our goal is to move AMB patient access from decentralized to a centralized model reducing the number of staff needed. Currently we are experiencing a staffing shortage with too many seats to fill, train, and retain. There are also higher expectations of skill needed on these front-end positions based on industry/payer changes. Patient Access is required to know registration, scheduling, and some prior authorization, while also meeting their department's' secretarial needs. This turns them into a "jack of all trades" rather than an expert in their area. There is no structured career path for patient access at present, leaving staff in an entry level position for their entire career.

Project Aim: What is your goal and how will it be measured?

Accomplishing this goal will provide a stable solution as we continue to see a trend in staffing shortages. Coordinated training will save time/labor cost in training of new hires, filling seats faster. Skill sets will be expected to increase with coordinated training resulting in fewer errors on the front-end as well as the back-end. Also offering a career path to decrease the chance of losing high performing employees due to the lack of opportunity to grow, lack of engagement and job satisfaction. Also, by offering a remote work position for functions such as prior authorizations would be attractive to those seeking remote employment and widening our applicant pool.

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What did you do to make a change?

Starting in May we began reviewing all position's current tasks, productivity summary reports in Expanse and compared them to full-time employees (FTEs) needed by position to the National Association of Healthcare Access Management (NAHAM). Amy Newton, Patient Access Coordinator, spent a significant amount of time observing the workflow in each position, documenting, reworking and streamlining the workflow while also working with our IT team to make the process work on Expanse across departments. By June we offered cross-training, the career steps and a raise in each position. Starting Aug 1st we arranged for Primary, Specialty, and Lab/Rad to hold 5 registration positions **in** Primary Clinic waiting room, at the front of the building. In 3 departments we have 1 check-out desk/scheduling position and 1 remote scheduler. The prior authorization positions remained in the same office with the potential of hybrid work in the future. And in a happy occurrence we were able to retain our (Covid) Door Monitor, after the doors were unlocked July 25th, by transitioning her to a Patient Assistant/Way-Finder. We also worked on details like chemo patient check-in by passing normal registration, flexible schedules for our registrars and a promotional push with our marketing team to increase use the patient portal.

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STUDY

	BASELINE VALUE	*Baseline Date*	REMEASURE VALUE	*Remeasure Date*	Did you improve ?
METRIC #1	8:14 FTE positions filled	*5/20/2022*	11:11 FTE positions filled	*7/22/2022*	Yes
METRIC #2	Patient Satisfaction- 2 documented complaints in 1 month related to patient access	5/31/2022	Patient Satisfaction-# documented complaints in 1 month related to patient access	8/31/2022	NA

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

In the decentralized model we had 8 registration/scheduling, 4 scheduling/prior auth, and 2 assistant positions across 4 departments. We where short staffed by 6 positions and received an additional resignation for 1 position. By moving to the centralized model and dividing by function we consolidated to 4 registration, 5 schedulers and 2 prior auth positions. We offered the remaining staff to move up a step, a wage increase and specialized training, offered 1 a remote position which reversed the resignation, and filled 2 entry level positions. We also hope to improve patient satisfaction based on reported complaints.

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ACT

Adopt, Adapt, or Abandon?	Adopt
Changes to be made?	Divide Functions – entry-level, step 2, and step 3 Update wages and job descriptions Standardize workflows Update phone to a “hunt group” Update communications between depts using “work groups”
Lessons Learned?	There are so many moving parts we know this will still be a work in progress especially in communications between departments. Getting accurate workflows and cross-training took weeks but the staff was relived to become proficient in one function.
Next steps or future goals?	Offer more remote positions, restructure call-tree maybe add a switchboard operator, increase patient portal usage.
Conclusion	The move was for the better!

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Project Acknowledgements

- Amy Newton, Patient Access Coordinator
- Samantha Wiese, Director of Patient Accounts
- Alice Hopstad, Director of Primary Care Clinic
- Erin Aune, Director of Specialty Care Clinic
- Stephanie Bennet, Software Analysist
- Marcie Sannon, Informatics Director
- Cami Kalinski, Director of Finances
- Ben Thoeny, HR Director
- Tisa Seiler, PI Specialist

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Missouri River Medical Center

PLAN

Background: Why did you choose this project?

We identified we are not meeting regulations and insurance requirements.

Project Aim: What is your goal and how will it be measured?

All admissions and current residents will have a discharge plan within 24 hours of admission. Be kept current during their stay with the changes in their care.

All charts will be audited during care plan meetings. New audit tool was created to be checked off during the admission process, and will be looked over within 5 days of admit.

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What did you do to make a change?

1. *Nurse' meeting's with training.*
2. *Saunders will be officially closed down as of Aug 31, 2022. No longer allowing access.*
3. *Admission audit tool, will be monitored.*
4. *Discharge Care Plan added to every patient*

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STUDY

	BASELINE VALUE	*Baseline Date*	REMEASURE VALUE	*Remeasure Date*	Did you improve?
METRIC #1	0%	06/01/22	100%	6/30/22	yes
METRIC #2	100%	07/01/22	100%	7/29/22	remained

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
All residents have an actual discharge plan that is in the new EMR

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Adopt, Adapt, or Abandon?	We have adopt the plan to maintain regulatory regulations and insurance compliance.
Changes to be made?	No additional changes at this time. Will continue to monitor
Lessons Learned?	New care plan process has added value and access availability to chart system in the EMR
Next steps or future goals?	Maintain 100% compliance through training.
Conclusion	We will continue to monitor this and correct as needed.

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Project Acknowledgements

- Janice Woodhouse, RN, DON, COO
- Samatha Carper, QA Coordinator
- Cindy Hunter, QA. Medical Records
- Emily Anderson, RN
- Christa Bronec, Care Plan Coordinator, LPN

Missouri River Medical CENTER FORT BENTON

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St. Luke Community Healthcare

PLAN

Background: Why did you choose this project?

Upon taking a closer look at EDTC data from the last year, we noticed we were not performing like our peers in 2 measures- Allergies/Reactions and Medication Review. Our ED manager took interest in the data and we were able to choose allergies/reactions as our measure du jour.

Project Aim: What is your goal and how will it be measured?

Our goal is to perform at or above 80% completion of allergies and reactions by the end of September 2022. It will be measured monthly with EDTC data.

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What did you do to make a change?

We educated leadership and staff about the data and gave out peer comparison reports. We reviewed the appropriate documentation routes in Meditech. We added a reminder function to nursing checklist in Meditech.

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STUDY

	BASELINE VALUE	*Baseline Date*	REMEASURE VALUE	*Remeasure Date*	Did you improve?
METRIC #1 Allergy/Reaction Documentation	47%	*1Q22*	54%	*2Q22*	Yes

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
April 22 individual data is terrible but the project didn't begin until May so of the month's the project was implemented rates were consistently above 60%. Buy in from nursing leadership and staff really shines here

NOTE: Only the what is written in the second table and rate of improvement will be displayed in the poster and not raw baseline and remeasurement data.

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ACT

Adopt, Adapt, or Abandon?	Adapt. Continue plan but add in monthly data sharing with ED staff.
Changes to be made?	Continue plan but add in monthly data sharing with ED staff.
Lessons Learned?	Storming between IT and nursing. Figuring out conflict styles and finding common ground. Person driven changes as Meditech isn't able to change what we wanted.
Next steps or future goals?	Future goals would be performing consistently above 95%.
Conclusion	We are on our way to our goal set for the end of September.

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Project Acknowledgements

Project Team Members Name & Titles

- Carly Ryther, QI Manager
- Stephanie Reffner, ED Manager
- Amy Rider, IT nursing documentation
- Shelley Phillips, Quality Data Analyst
- Abigail Byers, DON

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Takeaways

- Set a S.M.A.R.T Goal and start small
- Use tools to determine the root of the matter.
- Identify process measures to monitor improvement and compliance
- Use Big and Little Data.
- Fail early, fail often.
- Work with the willing and include the individuals doing the work on the improvement team
- Invite the patient and family perspective.

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Thank You For Your Time

Please complete the evaluation here:
https://www.surveymonkey.com/r/6TT3XG2

Don't forget to complete all session evaluations if you are looking for RN CE's!
Evals will close on Friday, August 5.
Links are found on the project page.