MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

Cultivating Roots of Quality Improvement

Session 8: Celebration & Sharing

August 22, 2023

- Central Montana Medical Center
- Community Hospital of Anaconda
- Dahl Memorial Healthcare
- Livingston HealthCare
- Mineral Community Hospital
- Ruby Valley Medical Center
- St Luke Community Hospital

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Central Montana Medical Center

Improvement in Primary Care Medication Reconciliation

PLAN

Background: Why did you choose this project? Why was it important to work on?

Medication reconciliation is vital to successful patient outcomes before, during, and after any health visit. An incorrect medication list can lead to medical errors and even adverse events for the patient and has been the source of poor care transitions in the past within our own facility and when communicating to others. We would like to clarify the current barriers for providers in completing medication reconciliations, who is and should be completing the medication history to set providers up for success in reconciliation, and also identify our current patient education process for medication management.

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

Our goal is to improve provider medication reconciliation compliance with primary care visits by 30% by August 2023. One provider and one nurse or medical assistant will be utilized for our small test of change. Accomplishing this goal will result in better care transitions, reduce medication errors, and improve patient safety. We hope to address barriers in provider and nurse success with obtaining an accurate medication list, as well as patient education barriers. We will utilize information technology and compliance/risk staff for education on the current and ideal processes, as well as EMR reports for measuring medication reconciliation compliance in hopes of seeing improvement.

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DO

What did you do to make a change?
Identify barriers and educate providers on EMR procedure through attending a provider meeting.
Meet with one provider and their clinical staff to gain feedback and provide education on completion of medication reconciliation.
Begin distributing medication list to patients for review with nurse prior to finalizing with provider.
Meet with project team monthly for updates.
Informatics staff to provide one-on-one education with providers as needed.
Attend provider meetings as needed for more education and feedback.
Monitor data monthly for improvement.

DO

Did you involve patient and family partners in your work? How?

We involved patient and family partners in medication reconciliation efforts by asking for their feedback when re-designing the mailed paperwork and reminders sent to them for Annual Wellness Visits (AWVs). We asked our Patient and Family Advisory Council (PFAC) members for input on the packets sent out prior to their AWVs, including the section asking for a list of their medications. Feedback received included a request to spell out OTC (over the counter) rather than abbreviating. Some patients did not understand what was meant by OTC medications and therefore the verbiage was changed to a more understandable and direct request.

Study

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Provider 1 - Medication Reconciliation Compliance	35%	58%	Yes

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

We did improve the compliance rate for medication reconciliation with one provider by providing focused education, just as we predicted. Compared to April 2023 at 35% compliance, one provider and their staff were able to achieve an increase of 23% by June 2023 to reach 58%. The introduction of printed medication lists for patients and their nurse to review prior to seeing the provider also may have aided in improvement.

ACT

Adopt, Adapt, or Abandon?	Adopt – We will implement and spread the change to other primary are providers.
Changes to be made?	Will modify education tailored to providers based off feedback from Provider 1 in our initial test of change.
Lessons Learned?	Nursing staff still can improve their consistency and accuracy in completing medication histories so providers can complete the medication reconciliation piece.
Next steps or future goals?	Ensure all staff are obtaining an accurate medication history and completing medication reconciliation through standardized workflows in the EMR.
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, aiding in patient safety efforts.

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Project Acknowledgements

- Kristy Heller, Quality Improvement Manager
- Lexie Jelinek, Quality Improvement RN
- Abbey Wichman, Director of Compliance and Risk Management
- Pat Gallagher, Informatics
- Amber Yaeger, Clinical Pharmacist

CMMC

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Community Hospital Of Anaconda

Cultivating Roots of Quality Improvement

ER Follow-Up and Wrap Around Care with PCP

PLAN

Background: Patients need to know what service they are coming in for, the results, what to do next, and who (PCP) can be there for them in those future next steps

Improve communication and services within the frontline regarding service type, findings and aiding with follow up. Improvements in these areas will directly and indirectly effect multiple measure matrix. Improve time and efficacy and communication with staff and patient. HCAHPS – patient satisfaction, reduce billing service complaints and 72hr ER Returns, Improve wrap around care with identified areas of concern for the patient and a Provider to address immediately or eventually, assisting patient with getting an established provider – having access to health care are a few areas effected.

***Project Aim:* Multi-directed improvement areas**

Our Goal is to reduce the % of ER encounters identified as not having a PCP by a 5% reduction by September 2023 (Review of June, July & Aug. '23 data that will be restricted to patients from surrounding area- peds and >65years old). A new baseline will be run for comparison since previous data was all inclusive). Members of this committee will accomplish goal by improving identified processes. Registration – hospital wide, Health Information and Social Services will improve inefficiencies to have PCP information recorded accurately in the EPIC system, for either systematic routing or manual processing. ADON, Nurse Managers, Registration (Hospital, Clinic, and ER) and Clinic Providers/Staff will streamline a process for ensuring patients get scheduling assistance before leaving the ER. Radiology, ER Providers & Nurses, HIM & Auditor, Registration, and various team members will ensure that patients are informed of their encounter results and pertinence is documented in appropriate locations (AVS, PMH, Snapshot, PCP routing) as well as the service classification they received (ER vs. CC).

DO

Test of Change: We found the right team members

January 2023 ideas evolved committee meetings towards this direction in March 2023. Through committee discussion tests of change were completed; in person, virtual, and electronic email transmissions and resulted in finding the right members, through trials this task was primarily completed in May 2023. The question was "Can we accomplish what we are setting out to with the individuals we have on the team?" If we did not have the right people, goals could not be set, establishing what results were needed, figuring out how to obtain them, and departmental wide communication could not be held, until the appropriate team was established. Members continue to be added or be the guest speaker in a meeting if their skill set assists the process.

DO

Test of Change: Awareness, Communication, and Documentation of Incidental Findings

February 2023 Incidental Radiology Reads significance and frequency were brought to ER and Radiology Staff awareness. Departmental meetings took place. Baseline processes were brought forth. Mostly were end user trailing the patient and communications. Outcomes are that preliminary and final read results needs to be discussed with the patient, documented on, having staff reach out during the ER encounter to Radiologist, PCPs, Specialists directly to provide efficient streamline care for patients. The analyst will address concerns directly with ER Providers vs department director. This process has full buy in of all ER and Radiology providers. This establishes a more direct discharge plan with less chasing of the patient for ensuring awareness of result and need for setting up PCP follow up appointments. First Qtr. 2023 averaged 7 encounters a month for addressing needs outside of the ER encounter to a current 2 for June.

DO

Test of Change: Decreasing Emergency encounters not identified as having a Primary Care Provider (PCP) for Wrap Around Care (WAC)

Base rate of ER encounters without having a PCP was 30% have been on the radar of Readmission Committee for years. This project got the focus on patients from the surrounding area, pediatrics, & those over 65yrs. 1st Qtr. 2023 averaged @ 4.6%. Focusing on that population and changed from end user review results to AM daily log reviews directed by Chief Clinic Officer for Clinic Nurses to ensure follow up needs for all ER encounters are met (post follow-up ER calls (a requirement to also assist in meeting PCMH requirements). Meetings taking place with registration, Health Information, and ADON as how best to improve the accuracy of filling the EHR PCP fields properly and communicating wrap around cares to the ER providers during that ER encounter. SS, HIM & Registration Directors are working with external facilities and providers to improve EHR access and record recovery that have multiple providers that carry out patient wrap around care. June data 5%. One area that is difficult to quantify is the dedication and daily work involved by the Clinical Staff to ensure all patients have opportunity for follow up to the ER encounter.

DO

Test of Change: Our facility provides Emergency (ER) and Convenient Care (CC) Services out of the same location

This component has many barriers, admission concerns and cares provided can be complicated and not necessarily straightforward at time of Triage as evaluation progresses patient designation may change from initial service class of ER or CC, Therefore, a patient may get an unexpected bill, the EHR may hold up the encounter for months wanting Rev Codes that will never come, the EHR has barrier withing the stages of an admission and fields that can no longer be revised due to updates or only by select staff. Tickets and meeting with EHR have been on going since Jan' 23. HIM has worked with an Auditor and ER providers to improve their awareness on service indicated, template usage, and communication with patient and ER staff. Meetings continue to take place with Registration Director and Clerks as well as Nursing and ER Committee to review Designation Guidelines, which were reposted by ADON, and continue to improve this process. First Qtr. 2023 had an average of 30 encounters a month changed by biller, in June 17.

DO

	March	April	May	June
Total ER/CC encounters	840	797	872	831
Conv. Care Encounters % in department	369	355	376	329
ER encounters	471	442	496	502
ER No PCP	91	95	99	104
ER Unknown PCP/blank	1	1	1	0
ER Peds 0-17 No PCP	11	8	7	10
ER >65Y No PCP	17	11	13	16
Denominator # with no PCP (Peds & 65&>)	27	19	20	26
Services changed to ER w/o problem within EHR (Electronic Health Record	9	8	0	3
Services changed to CC w/o problem within EHR (Electronic Health Record	11	12	12	8
Services charged ER unable to change Patient Class	7	0	2	3
Services charged CC unable to change Patient Class	11	12	5	3
Services changed/charged as ER	16	8	2	6
Services changed/charged as CC	22	24	17	11
Total Services changed	38	32	19	17
NO PCP pts that is outside current denominator data				78
ER Daily Requests	6	4	11	2

	March	April	May	June
Total ER/CC encounters				
Conv. Care Encounters % in department	44%	45%	43%	40%
ER encounters	56%	55%	57%	60%
ER No PCP	19%	21%	20%	21%
ER Unknown PCP/blank	0%	0%	0%	0%
ER Peds 0-17	2%	2%	1%	2%
ER >65Y	4%	2%	3%	3%
Denominator # with no PCP (Peds & 65&>)	6%	4%	4%	5%
Services changed to ER w/o problem				
Services changed to CC w/o problem				
Services charged ER unable to change				
Services charged CC unable to change				
Services changed/charged as ER				
Services changed/charged as CC				
Total Services changed	5%	4%	2%	2%
NO PCP pts that is outside current denominator data				75%

Involving individual providers and other local health care systems as a whole

This project has us involved with State, Federal and private Corporations: Montana State Hospital, Montana State Prison, Job Corp, START, WATCH, VA System, Care Here, Community Health, & Cottonwood Clinic as well as our own providers as how best to improve, streamline, and efficiently communicate patient treatment, concerns to be addressed within wrap around care, and assist with immediate and future needs follow up needs. Promoting a seamless transition of care and providing communication to community services to continue those needs for our patients.

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Study

	BASELINE VALUE per month	REMEASURE VALUE per month	Did you improve?
Incidental Findings Follow up	7	2	YES
PCP Not Identified in EHR	30%	New base 4.6% to 5%	YES
PCP Wrap around assist	End User	To Frontline and Wrap Around Staff	YES
Service Identified and Billed as same	30	17	YES

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

Improvements (nearly 50% or more in each area)have been noted in the four focused areas primarily through staff awareness, buy-in to the cause, and desire to improve. Barriers not yet manipulated within the EHR is a current focus in the latter three areas that could bring about the most improvement yet; having accurate, adjustable, user-friendly fields for information input.

ACT

Adopt, Adapt, or Abandon?	This committee abandoned the idea of having an all-inclusive team from the get go. Members will be invited as the progression occurs and their know how will be called on at those needed times. Adapted to remote communication with each other for meetings and sharing data findings and updates. Our meetings were online with onsite option with door always open to all. Committee concerns/minutes
Changes to be made?	Elimination of multiple indirect communication methods among ourselves was replaced with in-person communication. Clinic Directors took on a direct role to ensure ER follow-ups were completed.
Lessons Learned?	Learned that throughout all the areas of focus staff awareness to the situation/concern/data, education and direct communication was monumental in getting buy-in. Large improvements noted from that and individual desire to improve the process for the patient. Discussion and sharing knowledge of roles in past practices vital in order to peel down the layers and improve together.
Next steps or future goals?	Dive, dive, dive into EHR capabilities for record access, provider identification as PCP, routing history options- uncover and resolve the layers that present. QA and staff awareness to keep trends of improvement moving.
Conclusion	Leave you with this abstract: Most would think four distinct areas of concern could not be one project, although aren't they all communication tools and wrap around care!

MH

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Project Acknowledgements

Project Team Members Name & Titles

- Amy Reisenauer ADON/Education
- Halli Perala CCO
- Jamie Johnson CNO
- Jessica Dailey Clinic Registration
- Jessie Crawshaw Nurse Manager
- Judy Wonnacott Clinic Nurse Manager
- Kathryn Hall SS
- Kelly Skocilich UR/IC
- Kristen Villa Nurse Manager
- Kristi Danforth Clinical Analyst
- Mary Bisch HIM Director
- Mary Pat Ford COO
- Rae Lynn Reynolds UR/IC
- Sally Smith Registration Director
- Sherrie Patterson ACO, CCM Clinics
- Susan Kaasch SS Director
- Trish Wagner Business Office Manager
- Ty Tyvand Pharmacy Director
- Janet Fuller Radiology Director
- Michelle Christian ER Registration
- Sara Blaskovich ER Registration

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Dahl Memorial Healthcare Association

UTI/Abx Study

PLAN

Background: Why did you choose this project? Why was it important to work on?

Noticed an uptick in Urine Cultures being ordered – for various reasons. Ensure Antibiotics were/are being prescribed appropriately.

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

Big Picture Goal: Antibiotic Stewardship
More detailed goal: Figure out when/why orders are placed for Urine Cultures

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DO

What did you do to make a change?

1. *Poll: Asked ED/Clinic Nurses what the diagnoses are for the orders they're being asked to place for Urinalysis Dipsticks/Urine Cultures.*
2. *Look into how many of these cultures came back "No Growth" when ordered for invalid diagnosis codes.*

DO

Did you involve patient and family partners in your work? How?

Studied the results and reports from our reference lab (micro is not currently performed in-house) to compare the patient diagnoses and outcomes.

Study

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

Asking the nurses turned out to be an interesting poll. The criteria for ordering a urinalysis with a culture was if the urine sample itself was "nasty – dark and smelly – super cloudy…etc." When questioned a bit further, our nurses stated that they deferred to the ordering provider and/or laboratory staff for the culture criteria. One nurse was able to explain the importance of real, laboratory data. Antibiotics can treat a real UTI – they can seriously cause harm to a patient who simply has "dark and smelly" urine.

ACT

Adopt, Adapt, or Abandon?	Adapt
Changes to be made?	Education to be provided to nurses/providers on Laboratory based criteria for Culture ordering.
Lessons Learned?	SMALL tests of change! It's so easy to take on too much too fast and it quickly gets overwhelming. Keep it SMALL and simple.
Next steps or future goals?	Working in the Antibiotic piece of the puzzle. What Abx are being ordered? When are the Abx orders being prescribed (before/after completion of culture results?)
Conclusion	There was so much learning in this project and so much yet to come. I will conclude that we are appropriately ordering cultures and will report further when more information is available, regarding Antibiotics.

Project Acknowledgements

Project Team Members Name & Titles

- Elizabeth (Libby) Barth, MLT – Infection Prevention

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Livingston HealthCare

BBP Post Exposure Process

PLAN

Background: Why did you choose this project? Why was it important to work on?

Avoiding occupational blood exposure is the primary way to prevent the transmission of bloodborne pathogens. However, postexposure management is an integral component of a complete program to prevent infection following exposure and is a significant element of workplace safety. Exposures can lead to infection with hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), or other bloodborne pathogens. Knowing and expediting the postexposure process is vital because, in some cases, treatment may be recommended and should be started as soon as possible. Unfortunately, at Livingston HealthCare, there has been an increase of exposures in the last year and a noticeable gap in the post-exposure process. The current opportunities for improvement at Livingston HealthCare include refining the postexposure resources, creating a clear definition of the roles of responsibility, and emphasis on ongoing education to high-risk team members.

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

Our project aims to educate staff on the post-exposure process to eliminate knowledge gaps and increase employee safety. Few resources are available to the team, and those resources need to be reevaluated and enhanced. With more resources, the staff will understand exposure and post-exposure processes more, improving what happens after a BBP exposure and sharps safety. We plan to survey high-risk departments to understand their knowledge of the post-exposure process and assemble educational pieces for the populace and prepare to engage more with new employees about BBP and exposures at our New Employee Orientation. Specifically, I would like to create a BBP exposure segment in NEO, procure a badge buddy with the BBP postexposure process for all employee badges, and streamline the process for the House Supervisors. The initial survey will collect data regarding the current understanding of BBP post-exposure from high-risk departments. Then, after education and more resources are available, we plan to retest/survey competency.

What did you do to make a change?

Meetings were held with LHC staff who have experienced exposure, the DON, and the CNO to determine the areas that needed to be refined, which roles have what responsibilities, and where the gaps were in the post-exposure process. Initial surveys were sent out to gauge the knowledge of high-risk staff before implementing small tests of change. Employee Health, Nursing Administration, House Supervisors, and Infection Prevention roles and responsibilities have been defined and refined. We have noted that a specific post-exposure procedure has not yet been created and added to the LHC policy catalog. The Quality team has met with the Infection Prevention Nurse to streamline the duties of the House Supervisor when there is an exposure and are in the process of creating new documentation for the BBP Post-Exposure folders. Continuous monitoring of the BBP post-exposure process was assigned to the Quality department in the absence of the Employee Health position. Re-education will be completed as necessary, and new employees will receive post-exposure education at orientation.

DO

Did you involve patient and family partners in your work? How?

Meetings were held with LHC staff who have experienced exposure, the DON, and the CNO to determine the areas that needed to be refined, which roles have what responsibilities, and where the gaps were in the post-exposure process. Initial surveys were sent out to gauge the knowledge of high-risk staff before implementing small tests of change. Employee Health, Nursing Administration, House Supervisors, and Infection Prevention roles and responsibilities have been defined and refined. Re-education will be completed as necessary, and new employees will receive post-exposure education at orientation. A secondary survey will be sent out to high-risk staff after providing ongoing education and a more defined process has been confirmed. Conversations about appointing who will monitor the employee's lab results were completed. Discussion of and the remediation of the Employee Encounters confusion was had with CNO and DON—discussion and appointment of who covers Employee Health in the interim and when Infection Prevention is unavailable.

DO

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
METRIC #1	84%		

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

This has been a slow process as we have discovered that many areas in this project need improvement. We noticed that there needs to be more education for all staff members, and we are currently working on what that will look like as we move forward. We noticed that when there is an exposure, the House Supervisor, already tasked with their day-to-day duties, has much to complete inside our existing BBP Exposure folders and may cause a bottleneck in the process and an unnecessary burden to that team member. We have noticed that with conversations around this topic, there is more engagement and base knowledge for employees involved. Also to note is that 84% of the high-risk staff that took the initial survey, knew that washing/flushing the exposure site was the first step in the process. I hope, after education, to raise that number to 100%.

Adopt, Adapt, or Abandon?	Adapt the interventions developed in this project.
Changes to be made?	Create easily accessible resources for all team members. Defining roles and responsibilities. Structuring Employee Encounters.
Lessons Learned?	Poor communication reduces quality, weakens productivity, and eventually leads to anger and a lack of trust among individuals within the organization. Ensuring that roles and responsibilities are defined allows for better communication and trust amongst staff. Having resources that are easily accessible and consistent allows for prompt remediation and follow-through as well as less burnout to House Supervisors who carry a significant portion of the responsibility during an employee exposure.
Next steps or future goals?	The next PDSA is to add the post-exposure process to employee badges, have a segment in NEO, and work to define roles for staff further once the newly hired Employee Health Nurse has settled in. Using the strategies that were developed and lessons learned from this project, Livingston HealthCare will develop a consistent process for the post-exposure process to ensure proper remediation and communication between employees.
Conclusion	This PDSA cycle taught us that repeating ongoing education is key to awareness. Consistent and convenient resources allow team members to get the care and follow-up they need and deserve to remediate any high-risk situations. Emphasizing Employee Safety is just as important as Patient Safety. Employees need to know what resources are available and what they are to do in emergent situations. They must feel secure that their colleagues and the post-exposure process will support them.

Project Acknowledgements

Project Team Members Name & Titles

- Kathy LaBaty, Quality Director
- Chantel Hicks, Quality Assistant

Livingston HealthCare
Billings Clinic Affiliate

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Mineral Community Hospital

Improving HCAHPS Response Rates

PLAN

Background: Why did you choose this project? Why was it important to work on?

MCH felt that the amount of surveys we were receiving back from our HCAHPS were so small, that it wasn't giving us accurate information.

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

Our goal is to increase the amount of HCAHP surveys returned. It will be measured by when we receive our quarterly report from our outside vendor – tracking the amount returned.

DO

What did you do to make a change?

We created a copy of the envelope that the survey comes in and included it in our discharge paperwork. Our discharge planner reviewed what the survey was and how it helps us prior to discharge.

DO

Did you involve patient and family partners in your work? How?

We did involve patients with educating them and their families at discharge to keep a look out for the HCAHPS envelope and how important the contents of the survey are for us.

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Study

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
METRIC #1	37%	Have not received new information	

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
We aren't able to tell yet, as we have not received our last quarters numbers from our third party vendor.

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ACT

Adopt, Adapt, or Abandon?	Adopt
Changes to be made?	Showing patients what the mailer looks like. Discussion about the survey prior to discharge.
Lessons Learned?	If you'd like something filled out and returned it is best to discuss with those that will be receiving it. Especially with spam and such these days.
Next steps or future goals?	Continue efforts toward HCAHPS response rates, once we get more responses we will be able to drill down to the most important low scores and work on improving those internally.
Conclusion	Overall, even if our scores don't improve, or response rates stay the same, it felt better to give our patients a heads up to what they may be receiving in the mail and what it is. This gives them at least the opportunity to express their feelings about the stay.

Project Acknowledgements

Project Team Members Name & Titles

- Alex Conrow, Director of Clinical Services

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Ruby Valley Medical Center

Patient falls on the floor

PLAN

Background: Why did you choose this project? Why was it important to work on?

We had a sentinel event at the hospital, which made us aware of where we were falling short in our patient care.

This should not have happened. We had an increased number of falls, and the patient that fell was in the hospital for a fall and was not able to have surgery. She passed away in our facility

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

Our goal is to decrease falls to one or less per week. We will be keeping a record of them daily and will work with the nurses on the floor to ensure they are not missing anything to help prevent these.

DO

What did you do to make a change?

We have added motion alarms to all of the chairs in the patient rooms.
All alarms on the chairs and beds will be plugged into the wall to ensure they are heard at the nurse's station.
Physical therapy and nursing will communicate patient needs either on the whiteboard in the room or verbally.
Patients will be rounded on hourly or every 2 hours.
Patients will be toileted regularly- to decrease anxiety and agitation.

DO

Did you involve patient and family partners in your work? How?

We have included them as we are able.
We explain to patients and their families the need for the alarms to help patients comply with calling for help.
We will continue to remind patients to call for help on our regular rounds.

Study

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Number of falls	3	1	Yes
Communication on board	0	4	Yes
Alarms active and plugged in	2	4	Yes

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.
We have been increasing the number of post-fall huddles. This has helped to make it known what we expect and how to make sure it is implemented

ACT

Adopt, Adapt, or Abandon?	Adding alarms, communication and rounding
Changes to be made?	Nurse/Physical therapy working better together. Alarms use
Lessons Learned?	When we all work together, we do a better job of taking care of our patients.
Next steps or future goals?	Continue to monitor all aspects and do walk around to just check on status
Conclusion	We have done a great job, but there is always room for improvement

Project Acknowledgements

Project Team Members Name & Titles

- Ted W. CNO
- Charlotte L. QA/Risk, RN
- Nursing staff
- Therapy staff (PT, OT, and ST)

Ruby Valley Medical Center

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ST. LUKE COMMUNITY HEALTHCARE

ED TRANSFER COMMUNICATION

PLAN

Background: Why did you choose this project? Why was it important to work on?

IT has been attempting to pull reports and write code to capture EDTC data. The reports are consistently showing us to be at only 50-60% on this measure, which is inconsistent with the feedback from staff and audits performed by department manager. No feedback has been received from receiving facilities to indicate that we are falling short or not fulfilling EDTC requirements.

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

Our goal is to be at 100% as this is an all or nothing measure. Manual audits will be completed by the department manager to measure progress/success.

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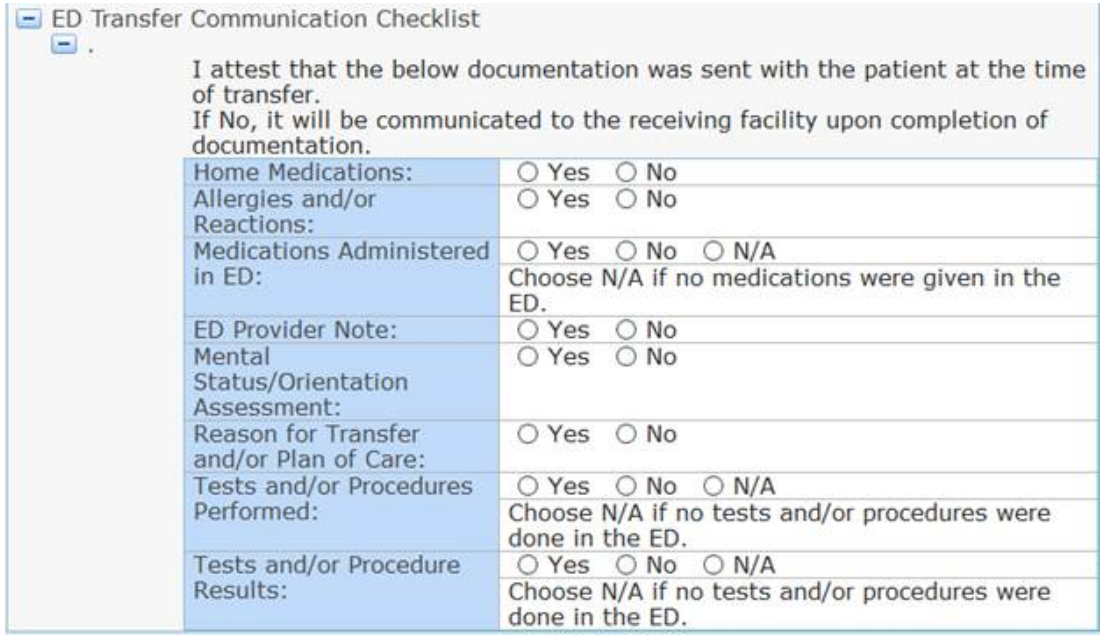
DO

What did you do to make a change?

We worked together to develop an EDTC intervention checklist that Amy built into Meditech to ensure required items are completed/documented for transfer. This is completed by either the Ward Clerk or RN, whomever is compiling the transfer packet. An email was sent out to staff on 6/8/23 explaining the process and reason behind it, including a screenshot of the new intervention.



ED Transfer Communication Checklist

.

I attest that the below documentation was sent with the patient at the time of transfer.
If No, it will be communicated to the receiving facility upon completion of documentation.

Home Medications:	○ Yes ○ No
Allergies and/or Reactions:	○ Yes ○ No
Medications Administered in ED:	○ Yes ○ No ○ N/A Choose N/A if no medications were given in the ED.
ED Provider Note:	○ Yes ○ No
Mental Status/Orientation Assessment:	○ Yes ○ No
Reason for Transfer and/or Plan of Care:	○ Yes ○ No
Tests and/or Procedures Performed:	○ Yes ○ No ○ N/A Choose N/A if no tests and/or procedures were done in the ED.
Tests and/or Procedure Results:	○ Yes ○ No ○ N/A Choose N/A if no tests and/or procedures were done in the ED.

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DO

Did you involve patient and family partners in your work? How?

No, we did not involve the patient or family partners in our work.

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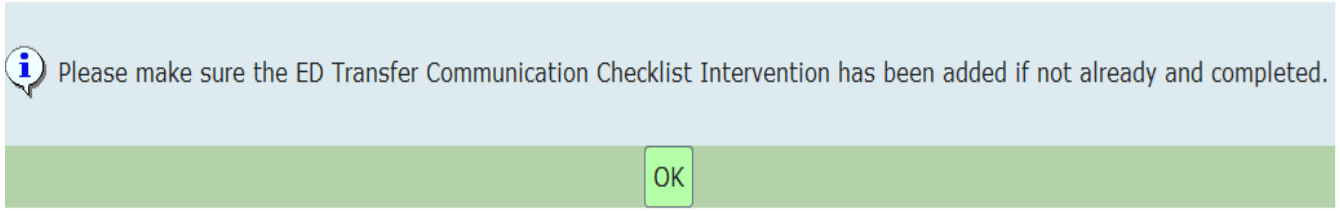
Study

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Implementation of EDTC Checklist	50-60%	75% (3 of 4 charts)	Yes
Addition of pop-up reminder/query	75%	100% (7 of 7)	Yes

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

Implementing the EDTC Checklist intervention in Meditech and then adding a query that if answered "yes," triggers a pop-up reminder to complete the EDTC has helped to bring us up to 100% on our re-measure value.



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ACT

Adopt, Adapt, or Abandon?	Adopt
Changes to be made?	Not at this time
Lessons Learned?	Computer analytics cannot capture all things in a report
Next steps or future goals?	Continue to audit and solicit feedback from staff involved
Conclusion	Going back to basics via the simplicity of a checklist, and involving frontline staff has helped to meet quality metrics and give credit for the excellent work that staff do to communicate with receiving facilities.

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Project Acknowledgements

Project Team Members Name & Titles

- Abigail Byers, DON
- Stephanie Reffner, ED Manager
- Amy Rider, IT Specialist

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Evaluation

Please complete the short evaluation that will appear when you leave the webinar.