Community Hospital of Anaconda
Anaconda, MT
Bed size: 25

**SETTING THE STAGE**

**Why did you select this project and what methods were used to identify the need?**

> CHA (Community Hospital of Anaconda) had been compiling data related to readmissions. Data gathered was submitted to the Quality and Safety Networks: Performance Improvement Network (PIN), and Hospital Improvement Innovation Network (HIIN) with Health Research & Educational Trust (HRET). As a result of data submission, CHA was provided an opportunity to review national and local benchmarking parameters related to readmissions with a goal to reduce readmissions by 12%. CHA was at an 8.5% readmission rate on average with a goal to reduce the rate to 7.5%.

> Opportunities to improve were guided by External Regulatory Groups and the foresight of CHA’s Administrative team to expand into services that would improve the overall health of our community.

> Further efforts are aimed at ongoing implementation and understanding of quality measure rules, as well revamping of our patient management meetings. After daily rounding had been implemented, the group, including the hospitalist and ancillary departments, concluded that the meeting could be improved with the addition of the ACO nurse case manager and the home health nursing director.

The attendance of the ACO nurse and Home Health Nurse Manager have positively impacted the readmission numbers and have allowed the group to focus on other areas that show an opportunity for improvement.

**PROJECT DESIGN**

**Who was involved in the improvement effort?**

> JoEllen Villa, newly appointed CEO-works with the project team on continual process improvement for quality reporting measures.

> Kristi Danforth, RN Clinical Analyst- currently working as a clinical review analyst with 2 years of experience. Processes data and participates in the quality improvement process with data analysis and reporting.

> Kelly Skocilich, RN Utilization Review Coordinator/Infection Prevention-currently works with staff and patients on discharge planning by attending daily rounds and assessing appropriate level of care for all patients from admission to discharge.

> Sue Kaasch, has a masters’ degree in Social Work -works with patients on an inpatient and outpatient level to assist them in establishing attainable discharge plans. Well versed in Home Health, Hospice, ER and other available outpatient resources.
How long did the development, design, and implementation of this initiative/intervention take?
> With exclusion of the Influential Background/History in the QAPI cycle, 12 months.

What was the desired scope of the impact (e.g. specific patient population, cultural change, etc.)?
> Improve care by reducing avoidable readmissions related to possible missed opportunities in care coordination. To implement safeguards within the patient care environment to assure a safe transition from acute care to home including home health, hospice, outpatient services, home health aides, medication management.

DATA COLLECTIONS AND RESULTS

Describe the data collected and results demonstrated from the start to end of the project.
> It is apparent from the data below that there was significant improvement in patient falls at GMH from the activities in 1st quarter 2018.

| Quality Assessment Performance Improvement – QAPI % of Improvement |
|---|---|---|
| Cycle 1 | 2001 – 2nd Qtr. ’17 Baseline | 8.50% baseline |
| Cycle 2 | Oct ’17 – Nov ’17 | 2.58% improvement |
| Cycle 3 | Nov ’17 – June ’18 | 1.67% improvement |
| Cycle 4 | June ’18 – July ’18 | 1.87% improvement |
| Cycle 5 | July ’18 – | |

Goal

Axis Title

All cause/Medicare Readmissions

Goal readmissions

<7.56%

Axis Title

Goal

<7.56%

12/14-5/15
10/31/2017
11/30/2017
12/31/2018
1/31/2018
2/28/2018
3/31/2018
4/30/2018
5/31/2018
6/30/2018
7/31/2018
8/31/2018
9/30/2018
Average

Goal
### DATA COLLECTIONS AND RESULTS

#### Quality Assessment Performance Improvement – QAPI% of Readmissions

<table>
<thead>
<tr>
<th>Cycle 1</th>
<th>2001 - 2nd Qtr '17</th>
<th>8.50%</th>
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<tbody>
<tr>
<td>Cycle 2</td>
<td>Oct '17 - Nov '17</td>
<td>5.92%</td>
</tr>
<tr>
<td>Cycle 3</td>
<td>Nov '17 - June '18</td>
<td>4.25%</td>
</tr>
<tr>
<td>Cycle 4</td>
<td>June '18 - July '18</td>
<td>2.38%</td>
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#### QAPI % of Improvement per cycle

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*Lessons learned:*

1. **Make Care Safer by Reducing Harm Caused in Delivery of Care;**
   Assistant Director of Nursing continues to lead education on fall prevention, policy and procedure review and revision for Adverse Drug Events; hypoglycemic medications have occurred, reduce avoidable readmissions related to care coordination, implement safeguards within the patient care home environment to assure a safe transition from acute care including home health, hospice, outpatient services, home health aides, medication management.

2. **Strengthen Person and Family Engagement;**
   Patient Experience Coordinator position created in late 2017.

3. **Promote Effective Communication and Coordination of Care;**
   Bringing together Patient care team weekly and consistently with our ACO Nurse, Home Health Nurse, Nursing Home Representative for discharge planning main goal to prevent readmission. ACO Care Coordinator attends daily hospital rounds and weekly Home Health Meetings to ensure comprehensive care for our patients during hospital discharge and when they need more care.
LESSONS LEARNED

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4. **Promote Effective Prevention and Treatment of Chronic Disease;** ACO & PCMH – Transitional Care Management (working with the hospital to get Medicare discharged patients to their appropriately timed follow up appointment with needed medications and services, working on a process for phone calls to be made to all of our ER and Convenient Care patients within 2 days of the visit). In the makings of Care Coordination Management program to work with Medicare patients with 2 or more chronic conditions, to help them better manage their conditions (arthritis, asthma, diabetes, hypertension, heart disease and osteoporosis) through support, education, coordinating of care to specialists, primary care, 24/7 emergency care medication review, and phone call check-ins.

5. **Work with Communities to Promote Best Practices of Healthy Living;** Brought in multiple services to this area, Care-a-Van use for medical needs. One process in the works is to include tracking our patients that were transferred out for services and ensure that they are getting appropriate follow up care. Medicare Annual Wellness Visits is our Care Coordinators main project at this time.

6. **Make Care Affordable and the reasons for these outcomes;** More specialties have been brought in for local outpatient services including telemedicine, and continue with Convenient Care as well as Emergency room open 24 hours a day. Wellness visits and follow up visits remain vital in decreasing inpatient stays.

SPREAD AND SUSTAINABILITY

There are so many moving parts to this one process that we hope we have shown through this exercise just how committed we are. Therefore, many of our daily actions play a role in this ultimate goal; reduction of readmissions. As CHA we are committed to ensure that our community is served the very best that we can provide.