Great River Health System (GRHS) contributions to the Iowa Healthcare Collaborative Hospital Engagement Network over the past year have proven that hospitals can provide safer care by reducing harm through focused performance improvement. This report illustrates our work and the work that will continue in the future to ensure great care every time for our patients and their families.

2013 Hospital Engagement Network Report
Introduction

Great River continued the work we started in 2011 with emphasis on “fine tuning” improvements in the identified focus areas. The Iowa Healthcare Collaborative re-emphasized the importance of monthly data reporting as the Centers for Medicare & Medicaid Services (CMS) recognized nationally the success of hospitals in Iowa.

This report illustrates GRHS’ IHC Collaboration Evaluation, current data and interventions employed for each area. The Quality Resources department would like to offer special thanks to the various focus leaders and task forces that are working on “zero harm” for our patients.

Great River Health System Evaluation by IHC

In March 2013, Dr. Evans presented his plan for improvement capability for all hospitals participating in the Hospital Engagement Network (HEN) Partnership for Patients (PfP). This plan included the evaluation of hospitals based on a Z-Scale. Previously, the HEN focused on development of capacity to improve through work plans and reporting. The Iowa HEN 2013 Goal was to help hospitals achieve and demonstrate improvement capacity (Score of “3”) by September 1, 2013. Great River met this goal. This score is a “hospital-based score” and is not a reflection of a statewide comparison. The evaluation period (explained below) was for an abbreviated period of time; i.e. 2 months beginning January 2013 through February 2013. The Z-score is based on a 5-point scale:

- 1 – Participating in learning communities
- 2 - Monthly reporting performance data
- 3 – Demonstrate “improvement”
- 4 – Sustainable “improvement”
- 5 – Mentor others

**Z3 Score Categorization:**

In general for each PfP focus area metric, a hospital was categorized as a “Z3” performer in a focus area if the hospital’s actual performance was better than their own hospital’s targeted performance rate and on target to achieve the PfP aims of 40% reduction in Hospital Acquired Conditions (HACs) and 20% reduction in Readmissions.

Baseline Period – the baseline period for this report spanned 6 months from January 2012 – July 2012. The same baseline period was used for each PfP focus area.

Baseline Measurement – a hospital-specific “baseline measurement” was computed as the aggregate observed rate of performance across the entire population reported by the hospital. A hospital-specific baseline measurement was computed for each PfP focus area metric.

Evaluation Period – the evaluation period for the first report spanned 2 months from January 2013 – February 2013. The same evaluation period was used for each PfP focus area metric.

**Z3 Monthly Target Rate** – A hospital-specific targeted performance rate was established for each month after the baseline period such that by the end of CY2013 the hospital’s targets achieve the PfP goals for adverse event reduction of 40% reduction in HACs and 20% reduction in readmissions. Thus, the algorithm the IHC HEN used to create Z3 Monthly Target Rates created targets that decline smoothly over time. The algorithm used also took into account the higher opportunity for a reduction in rates when rates are higher in earlier time periods. Finally, in the case that a hospital’s baseline measurement was “0” the monthly target rates were retained at “0”.

“Z3” Performance – For each PfP focus area, a hospital was categorized as a “Z3” performer in a focus area if the hospital’s actual rate was less than their hospital’s Z3 Monthly Target Rate in at least 1 out of 2 within the evaluation period.
In August, GRHS received our Z-score Report Q1 2013. We met the IHC goal of a “3”. **REMEMBER, THE SCORE IS NOT A COMPARISON OF IOWA HOSPITALS – IT IS A COMPARISON OF OURSELVES AND OUR ABILITY TO IMPROVE.**

We demonstrated 3 areas with a score of 4 (sustained high performance by meeting a 40% improvement of a national benchmark).

- Adverse Drug Event (Blood glucose < 50)
- Pressure Ulcers
- Readmissions

We demonstrated 6 areas with a Z-score of 3 (Demonstrating outstanding improvement by achieving standards per scoring guide).

- Venous Thromboembolism (VTE)
- Early Elective Deliveries
- Falls with injury
- Ventilator Association Pneumonia (VAP)
- Central Line Associated Blood Stream Infections

The remaining focus areas scoring 2 (Engaged in work related to HAC and submitting data on outcome measures):

- Adverse Drug Event (INR)
- CAUTI
- Surgical Site Infections

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<th>Falls w/inj</th>
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**Recommendations/Actions to be taken:**

- Continue work with Task Forces on identification of goals and improvement opportunities
- Attend Learning Communities Conferences and Annual IHC meetings to gather information on improvement opportunities
- Taskforces need to continue to meet routinely and measure data
- Report monthly data to IHC
- Seek opportunities via IHC to mentor other organizations
- Continue creating and distributing the HEN Newsletter and encouraging use of the data as part of the 3 Ps Bulletin Boards (i.e. Patient Safety, Patient Satisfaction, Performance Improvement).

**The Results of our Work**

**Hospital Associated Infections**

Healthcare-associated Infections (HAIs) are preventable infections that occur when patients seek medical care for a health condition, such as receiving dialysis or having surgery in the hospital. Because of the success of many of the interventions listed below, GRMC was awarded a Patient Safety Award by the Iowa Healthcare Collaborative in March 2013.

HAIs affect 5% to 10% of hospitalized patients, causing nearly two million infections, 90,000 deaths, and cost $4.5 to $5.7 billion each year nationally. HAIs have a variety of causes including use of medical devices, such as catheters
and ventilators; complications following a surgical procedure; transmission between patients and healthcare workers; or the result of antibiotic overuse.

These data identify the positive trends that have reinforced GRHS’ commitment to zero harm to patients. This is a journey and we will continue to make using data to drive the improvement process. As of the last reporting month, there are 0 infections related to catheters.

**Catheter-associated Urinary Tract Infections (CAUTI)**

**Leader:** Mary Moore

**Goal:** Target is 0 urinary tract infections due to catheter use

**Performance Improvement Methods Utilized:**

- Limit catheterization usage
- Remove catheter within 48 hours – surgical patients and within 48-72 hours- medical patients
- Proper catheter insertion technique
- Secure catheter properly
- Strict hand washing techniques
- Work with Champion Urologist to develop protocols of care, Continue RCA’s on all CAUTI’s
- Reporting to: Infection Control, HEN IHC and Performance Improvement Committee

Full bundle compliance was noted through September 2013.
Interventions to achieve lower CLABSI:

**Leader:** Mary Moore

**Goal:** 0 CLABSI, full bundle compliance

**Performance Improvement Methods Utilized:**
- Central line check list
- Prompt removal of unnecessary lines
- Scrub the hub of the catheter every time utilized
- Reinforce hand hygiene
- Reinforce maximal barrier protection
- Chlorhexidine skin antisepsis
- Optimal catheter site selection
- “Scrub the Hub” Campaign for clinical and medical staff, monitoring areas that access lines with Q&A’s, reinforce maximal barrier precautions, Utilize the subclavian vein as the preferred site for non-tunneled catheters

**Surgical Site Infections:**

Great River continues to work on surgical site infections using a full bundle compliance that is related to the CMS Core Measure set –Surgical Care Improvement Project (SCIP). Within the past year we have had a total of fourteen infections with an overall rate of less than 1%.
Great River has been above 90% for all reporting months; however has only met the target for full SCIP compliance for the first month of 2013.

**Leaders:** Mary Moore & Lori Plath

**Goal:** Greater than 90% on SCIP measures 1, 2, & 3

**Performance Improvement Methods Utilized:**
- Educate staff on time frames for SCIP 1, 2, 3
- Education for physicians through updated data regarding these measures
- Disease Specific Oversight Committee meets monthly to discuss non-compliance.
- Prompting and letters to physicians when outliers are identified
- SCIP “green sheet” has been created and is now available electronically to support the improvement on these measures

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**Ventilator-Associated Pneumonia (VAP)**
Leader: Mary Moore

Goal: Sustain 0 VAP

Performance Improvement Methods Utilized:
- Full Bundle Compliance
- Elevation of head between 30-45 degrees
- Daily “Sedative interruption”
- Daily assessment of readiness to extubate
- Daily oral cares
- Peptic ulcer disease prophylaxis
- Hi Lo Vac ET Tube, except for surgical patients

Although the HAI taskforce has had much success, work will continue in the future to sustain and identify opportunities for more efficient workflows.

Hospital Associated Condition – Pressure Ulcers

The prevention of pressure ulcers has been a long standing focus at GRHS, as well as at the State and National Level. Healthcare Acquired Pressure Ulcers are a Quality Indicator for the HEN, reported to NDNQI, and are a Never Event as categorized by CMS. The Wound and Skin Committee is part of the Clinical Nurse Resource Council and currently meets monthly. Pressure ulcer prevalence is assessed quarterly. Midas data was used to establish a baseline and for ongoing data submission to CMS and is measured monthly.

CMS states that there should be no Stage III and Stage IV Hospital Acquired Pressure Ulcers. The Wound and Skin Committee, in reviewing our data, NPUAP Standards, and CMS targets have set our threshold at a 40% reduction in hospital acquired pressure ulcers. Baseline data is from calendar year 2011. Also, in review, we have included Stage II hospital acquired pressure ulcers. This is a better sample and does reflect the GRHS inpatient population.
Assessment

Data for 2013 indicates a very low incidence with only 3 PUs being reported through September 2013.

At Risk Patients Receiving Full Pressure Ulcer Preventive Care

The target has been met and exceeded for patients who are at risk for pressure ulcers with full pressure ulcer prevention methods in place.

Goal or Target- To reduce Hospital Acquired Pressure Ulcers, including Stage II, III, IV (which includes non-stageable and Deep Tissue Injuries) by 40%.

The following action(s) have been taken:

- Plan education, including assessment and prevention techniques for the bedside nurse
- Increase pressure ulcer and wound care knowledge and skill for the Wound Resource Nurses serving on the Clinical Nurse Resource Council, Wound and Skin Committee. (on-going)
- Anatomical position document within the MR with assignment of wounds by nurse. A Wound Location document was added to the medical record to denote the location of each wound, skin abnormality and pressure ulcer. Each location is numbered and then referred to in the electronic medical record by that specific number throughout the stay. This is especially useful for patients with multiple wounds, pressure ulcers or other skin abnormalities.
Recommendation of COE:
- Consider changing the goal after reviewing recommendations from IHA
- Consider looking at future evaluation of assessments
- Update Wound Brochures and Reference materials
- Review all products currently in stock and their indications (preferences for use)
- Monitor the “safe handling” project to see if there is a correlation between the ability to move patients more easily.

Hospital Associated Conditions – OB Adverse Events

National initiatives have focused on eliminating inductions during weeks 37 to 39 of gestation. Although the mother is considered at term, clinical evidence has shown that inducing labor during this period increases the likelihood of negative health outcomes for the newborn and mother. Elective early term deliveries can lead to adverse neonatal outcomes such as increased neonatal intensive care unit admissions, transient tachypnea, respiratory distress syndrome, sepsis and feeding problems.

ACOG, IHI and March of Dimes have hospital-focused programs to guide implementation of 39-week rules. Currently, our Obstetricians follow the 39 week rule for elective inductions. GRHS is quite fortunate that our providers have been progressive in eliminating elective inductions except for reasons already mentioned. Since the inception of the HEN, GRHS has had no elective inductions. To support this practice for future on-boarding of new providers, the Medical Executive Committee (MEC) approved a rule and regulation change to including information regarding the protocol. This was approved by MEC in July 2012.

Great River also tracks and trends the number of C-Sections and determines causation.
Hospital Associated Conditions – Medication Adverse Events

As part of the HEN initiative, medication events have been divided into three areas: (1) The Use of Stat Narcan; (2) INRs greater than 5 for patients on warfarin therapy; (3) Blood glucose <50. The following details the work that began and continues in these areas.

STAT Use of Narcan outside of the ED

GRMC STAT use of Narcan outside of the ED is currently ongoing. Multiple data sources were explored in order to obtain information regarding the frequency of use. During review of these data sources, the Accounting Department was also notified of concerns regarding obtaining and administration of the medication due to a lack of documentation of charges.

In the first phase of data collection and analysis the frequency of use has been obtained along with drill down information. This information was presented to the Nursing Quality and Safety Council for action planning. Based on the drill down data at that time, agreement was reached to work on obtaining additional information regarding patients with diagnosed sleep apnea or risk of sleep apnea. Nursing Quality and Safety Council has requested additional information on the identified patient population as the move forward with action planning.

Approximately 1.3 million people are injured annually in the US as a result of a medication error. Great River Health System defines an adverse drug event as “Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. (National Coordinating Council Medication Error and Reporting definition).” Among this list of medications that have the potential for error (high risk medications) include: Insulin, Anticoagulants and Narcotics.

Assessment:

Each case of Narcan use identified on the Omnicell report has been reviewed for additional information. Review of the records indicates that Narcan is being used at GRMC mostly to treat symptoms such as nausea, vomiting, and itching. Record reviews are showing that on occasion Narcan ordered for respiratory depression being used for treatment of these symptoms. Nursing Q&S Council have been provided information regarding this project and to bring awareness of the frequency of use of Narcan for symptom treatment to the physicians. Nursing Quality & Safety and the Medication Safety Committee are asking if there is a possibility that other alternatives are available for medication for side effects or if additional meds could be added to epidurals to prevent side effects. Pharmacy is working with this council to determine an alternative for Narcan and this will be taken to the P&T Committee in the future.

Current Performance Indicators reveal a slight increase in August and September. The Pharmacy Department and the Patient Safety Coordinator perform root cause analysis on each case.
Actions that have been taken include:
1. Education of staff on assessment and options for caring for sedated patients.
2. Encouragement of staff to utilize the Rapid Response Team for support (Staff Development Newsletter)
3. Work with the Sleep Lab to evaluate and adjust the nursing assessment questions to identify possible sleep apnea patients.

**INRs >5 for Patients receiving Warfarin Therapy**

Pharmacy has been working to improve the care of GRMC patients on warfarin previously and continue to monitor patients. Capitalizing on work previously done and exceeding the goal set by the IHC HEN, GRMC continues to see a decrease in the number of patients with an INR of >5.

Approximately 1.3 million people are injured annually in the US as a result of a medication error. Great River Medical Center has defined an adverse drug event as “Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. (National Coordinating Council Medication Error and Reporting definition).”

**Assessment:**
Anticoagulation is part of the National Patient Safety Goals for The Joint Commission (TJC). Pharmacy continues to monitor our success with this patient population. Trends for inpatients with INRs >3.5: 2008 – 9.4%, 2009 – 7.4%, and 2010 – 7.4%. Trends for inpatients with INRs>6: 2008 - 2.6%, 2009 – 1.4%, and 2010 – 0.9%. Current performance shows that we have met the target for three different months in 2013.

**Current Performance Indicators**

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<th>March</th>
<th>April</th>
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Actions: All patients with INRs greater than 5 are reviewed by S. Thompson in Pharmacy.

**Blood Glucose <50 for Inpatients**

The Diabetes Disease Specific Care group has been working to improve the care of GRMC patients for some time. GRMC continues to work to reduce the occurrence of blood glucose readings <50 with the assistance of the physicians, nursing, and support departments such as Diabetes Education and Nutrition Services.

Approximately 1.3 million people are injured annually in the US as a result of a medication error. Great River Medical Center has defined an adverse drug event as “Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient,
or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use” (National Coordinating Council Medication Error and Reporting definition).

Assessment: Review of the blood glucose readings and discussion with the care group has focused on the subcutaneous insulin order set, proactive treatment of diabetic patients with lower blood glucose readings prior to sleep and the ongoing assessment of blood sugars and appropriate time frames on testing, medication administration, and follow up testing. Currently GRHS is at or below the goal.

Current Performance Indicators

<table>
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<th>HEN - Blood Glucose &lt;50 Great River Health System</th>
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<td>N: 52 51 51 50 49 49 49</td>
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<tr>
<td>D: 0.25 0.25 0.25 0.25 0.25 0.25 0.25</td>
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Actions:
- Increase utilization of standardized insulin order sets.
- The new Subcutaneous Insulin Order Set requires that meal consumption be monitored. If the patient eats < 50% of his/her meal, a 2 hour post-meal blood sugar is to be checked. This allows proactive monitoring for the patient who has hypoglycemia risk due to poor nutrition intake. Nursing is planning a change in the assignment sheet to support better identification of those patients that have this order set in use, reminding staff to retest glucose 2 hours PC if meal consumption is < 50%. This change took place in June 2012.
- January 2014 change to OPT-OUT order set. With announcement to all Medical Staff via the Medical Staff Committee Summary –Recommendations for a bedtime snack if less than 80% of supper is consumed or if there is a schedule bedtime insulin dose. Previously a bedtime snack was allowed only for bedtime blood glucose of less than 120mg/dl.
- Monitor the provision of snacks at bedtime and report to taskforce.
Hospital Associated Conditions – Fall

Reducing the risk of harm from falls was retired as a National Patient Safety Goal in 2009. Great River Health System (GRHS) continues to monitor patient falls in conjunction with The Joint Commission’s (TJC’s) requirement for compliance with standards included in the Performance Improvement and Provision of Care chapters.

In August 2011, GRMC completed hospital-wide fall prevention training. This training included all employees who spent any time in units where patients are present. The training emphasized that fall prevention is the responsibility of every employee at GRMC. The skill lab included: identification of bed and chair alarms, response necessary from non-clinical staff to alarms, identification of the high fall risk patients, and measures that can be taken to prevent patient falls.

The Hendrich II scale was adopted in August 2011 as the fall assessment scale. A mandatory in-service was presented to all RN’s and LPN’s which included instruction on completion of the Hendrich II scale and general fall prevention education. GRMC requires nursing staff to complete the Hendrich II scale each shift on every patient and reevaluate fall risk and interventions to prevent falls. In 2013 a Safe Lifting Program was implemented at Great River to help support safe transfers and protect staff from injuries.

Assessment

Monitoring of patient fall data occurs and is reported monthly to IHC and to the National Database of Nursing Quality Indicators (NDNQI). Total falls and falls with moderate to severe injury are currently collected and trended. This data is reported quarterly to The Quality and Safety Council, The Performance Improvement Committee, The Safety Committee, and to the Nursing Management Group. The number of “Days without Falls” is posted and updated biweekly on inpatient nursing unit.

Current Performance Indicators

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<th>Falls per patient days</th>
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Falls with Major Injury

There have been no falls with moderate to severe injury for the 14 months and then in February of 2013, we had one fall. A Root Cause Analysis and it was determined that nursing staff did everything within the “toolkit” to prevent the fall. As a result, the Taskforce leaders were invited to present at the IHC Learning Community meeting in the fall of 2012 and continue to be leaders in this area.

Hospital Associated Condition – Venous Thromboembolism (VTE)

A HEN group was created to develop and implement strategies to decrease the number of surgical patients who develop VTE. The process measures used include the number of acute surgical inpatients with full bundle compliance (numerator) in comparison to the number of acute surgical inpatients with VTE prophylaxis recommended (denominator). The outcome measures include the number of acute surgical inpatients who develop VTE (numerator) in comparison to the number of acute inpatient surgical episodes (denominator).

The VTE HEN work group’s overall goal is to decrease hospital-acquired VTE in adult surgical patients by four cases in 2013 and this was accomplished. Venous Thromboembolism (VTE) refers to both Deep Vein Thrombosis (DVT) and Pulmonary Embolisms (PE). VTE is a common preventable cause of health care-associated morbidity and mortality. Approximately 1.15% of hospitalized patients undergoing surgery experience a VTE. This amounts to over 100,000 cases per year. The risk for developing VTE varies between 10 - 85% (depending on reason for admission).

Current Performance Indicators
Actions:
The following action(s) have been taken:

- Random sampling being done on all other surgical patients who receive VTE prophylaxis or have documentation as to why no VTE prophylaxis was given within 24 hours of hospital admission.
- Pharmacy to meet with the orthopedic surgeons to discuss the increase in VTE in those patients who have received Xarelto as VTE prophylaxis. As a result this has medication has been discouraged.
- The following has been added to the Opt Out Order set for the adult patients - If pharmaceutical VTE interventions contraindicated then apply foot SCDs.
- Cerner will now include a VTE Advisor to support interventions (both pharmaceutical and mechanical).

Readmissions

In February 2012, collaboration was created between Great River Health System (GRHS) and the Iowa Healthcare Collaborative (IHC). The collaboration is called the Hospital Engagement Network (HEN). The HEN has set the ambitious goal to reduce hospital readmissions by 20% by 2013. Achievement of this goal will center on reducing complications during transitions from one care setting to another, particularly for patients with multiple chronic conditions. Seamless care transitions require thoughtful collaboration among hospitals, community-based organizations, patient caregivers, and patients themselves. A GRHS Readmission Taskforce has been established with Dr. Rommel Adajar as the physician champion and Karen Carter, Director, Case Management as the Lead.

Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care--for example from hospital to home or nursing home, or from facility to home- and community-based services--have been shown to be prone to errors. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days. This translates to approximately 2.6 million seniors at a cost of over $26 billion every year. Readmission rates are also high for patients covered by Medicaid and private insurance.

Medication errors, poor communication, and poor coordination between providers from the inpatient to outpatient settings, along with the rising incidence of preventable adverse events, have drawn national attention. Health care providers and community-based organizations are aware of the negative effects of poor patient care transitions. But many struggle with fragmentation and lack of collaboration across settings, limited resources, and an expanding aging population with multiple chronic conditions.

The IHC has set a crisp aim to: Reduce hospital readmissions by 20% by 2013.
**Assessment:**

The Readmission task force began meeting every two weeks and then was extended to monthly due to the Cerner Project. The purpose of the meetings was to: (1) Design a work plan (2) Agree on a GRMC goal for reducing readmissions based on data; (3) Develop interventions to reduce readmissions; (4) Analyze data to determine success of the interventions. A work plan has been developed. The following depicts the final decision of the task force to focus on a subset population of readmissions.

Each intervention has a work group that meets on an as needed basis to develop the interventions necessary to meet the overall goal.

These data illustrate two interventions being used by GRHS. The first intervention is the involvement of outside providers in the post-discharge needs assessment. This is accomplished by contacting the receiving facilities/organization and discussing the needs of the patients. The second is for follow-up appointments. We have seen a decline in the number of follow-up phone calls we are making and the focus work group will be reconvening to discuss this.
Teach back and information transferred as part of care transitions are the next process indicators. We are above 90% for each of these areas.

GRHS chose to do “free” home health visits for high risk patients. The taskforce will be discussing the indicator statement for this measure. In many instances, the patient does not qualify for a free visit (e.g. they already have home health services). This indicator does not reflect that actual work that is occurring and may be changed in the future.
As of October 2013, GRHS was performing well in the area of readmissions for all-cause 30-day readmits.

**IHC Results Statewide**

Dr. Evans, President and CEO of IHC have outlined the success of the HEN in Iowa. From the beginning, there has been 100% commitment of hospitals in the state to reduce readmissions and hospital-associated conditions. Historically, CMS awarded 26 organizations a two-year contract to help identify the key improvements and spread initiatives across their defined populations and IHC was awarded the sole Iowa-based contract to serve Iowa hospitals in this campaign. IHC works with the Iowa Hospital Association (IHA) and Telligen, Iowa’s Medicare quality improvement organization, to implement the program and serve as subcontractors. As a result of the positive work, IHC has been provided a 1-year non-compete award to continue the work. CMS will be focusing on more emphasis regarding standardized process indicators for all participants.

GRHS has been asked to participate in helping to identify these metrics and has been participating in monthly teleconferences with IHC and the Iowa Hospital Association. In addition, GRHS has been asked to participate in a CMS focus study on OB EED being conducted by the Health Services Advisory Group (Arizona QIO) beginning in December 2013.

**IHC HEN Direction for 2014**

- Prepare physicians for the future (Physician Engagement)
- Align and Equip Providers
- Maintain a high level of monthly reporting
- Raise the standard of care
- Focus on standardized metrics across the state and nationally
- Focus on adverse medication events.
**Evaluation of the Past and Anticipating Future Needs**

**Status of 2013**

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<th>Goal</th>
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<td>Align goals of HEN with Strategic goals of Health System</td>
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</tr>
<tr>
<td>Participate with IHC on physician engagement activities</td>
<td>Ongoing. More work is needed here.</td>
</tr>
<tr>
<td>Focus on reduction of readmissions and care transitions</td>
<td>Partially met. Due to the Cerner Project monthly meetings were not always possible.</td>
</tr>
<tr>
<td>Establish alignment with Klein Center for care transitions</td>
<td>Ongoing</td>
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<tr>
<td>Continue to report metrics to IHC on monthly basis</td>
<td>Completed</td>
</tr>
<tr>
<td>Work with IHC to establish statewide metrics</td>
<td>Started in December 2013</td>
</tr>
<tr>
<td>Sustain improvement in HAIs, Pressure Ulcers, OB Adverse Events, Falls</td>
<td>Continue monitoring</td>
</tr>
<tr>
<td>Demonstrate improvement in VTE, Readmissions, Adverse Drug Events</td>
<td>Continue working on interventions and re-measurement</td>
</tr>
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**Plan for 2014**

Strategic Goal: Create a culture of quality and safety that will meet or exceed all state and federal benchmarks.  
Strategic initiative: Participate in HEN

<table>
<thead>
<tr>
<th>Goal</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Align goals of HEN with Strategic goals of Health System</td>
<td>Review and confirm with PI</td>
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<tr>
<td>Focus on reduction of readmissions and care transitions</td>
<td>Work with Care Transitions team; monitor and report</td>
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<td>Establish alignment with Klein Center for care transitions</td>
<td>Identify key stakeholder at Klein and have them attend COE meetings</td>
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<td>Continue to report metrics to IHC on monthly basis</td>
<td>Monthly data collection and upload to IHC</td>
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<td>Work with IHC to establish statewide metrics</td>
<td>Participate actively in calls</td>
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<td>Sustain improvement in HAIs, Pressure Ulcers, OB Adverse Events, Falls</td>
<td>Monitor and report</td>
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<td>Review CMS Focus Review Information and develop interventions, if applicable</td>
<td>Monitor and report</td>
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<td>Mentor at least two other hospitals during reporting year.</td>
<td>Identify opportunity via Advisor and support (via phone calls, sharing of information)</td>
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<td>Increase Z-score in the area of Adverse Drug Events (INR) and Surgical Site Infections (at a minimum from a 2 to 3)</td>
<td>Re-convene taskforce and re-design interventions.</td>
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<tr>
<td>Improve VTE bundle compliance in the area of provision of discharge instructions</td>
<td>Identify other benchmark discharge materials and design plan to distribute now and later in Cerner.</td>
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