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| Goal 1: Improve the quality of life for residents of Reno County that are living with a chronic illness |
| Objective 1.1: Provide education to residents with Chronic Illness |

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| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 1.1.1: Provide chronic illness education via – brochures, telephone support, classes | March 2020 – March 2021  PHASE 1 – Congestive Heart Failure (CHF) | Director of CV Services | HRMC various dept  Hutchinson Clinic  Hospice and Home Health of Reno County (HHHoRC)  Prairie Star Healthcare |
| Strategy 1.1.2: Provide post discharge education to chronic illness patients that are un-insured via Community Care program | July 2020 – June 2021  PHASE 1 – Congestive Heart Failure (CHF) | Community Care Clinical Liaison | HHHORC,  HRMC - Care Management,  Sound Physicians,  HRMC - Cardiac Rehab and Pulmonology dept |
| 1.1.3 Develop methods to track patients that are admitted to the hospital with chronic illnesses. | July 2020 - March 2021  PHASE 1 – Congestive Heart Failure (CHF) | Director of CV Services  IS department | Hospice and Home Health of Reno Co.  Care Management Dept  Sound Physicians  Hutchinson Clinic  Prairied Star Healthcare |
| 1.1.4 Develop work flow to provide follow up calls to chronically ill patient on discharge day 1 and 3, to evaluate education needs and discharge plan of care. | July 2020 – June 2021  PHASE 1 – Congestive Heart Failure (CHF) | Director of Care Mgmt | Hospice and Home Health of Reno Co.  Care Management Dept  Hutchinson Clinic  Prairie Star Healthcare |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * # of new diagnosed CHF patients that were referred to a post discharge program * # of CHF patients with minimal resources that are referred to the Community Cares program |
| *Outcome Indicators* |
| * Number of community members provided education by at least one format for a chronic disease * Number of patients called post discharge with a diagnosis of CHF * Number of patients with CHF referred to Community Care * Number of patients with CHF in Community Care program with no readmission in first 30 days |

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| Metric 1.1 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| # of Community member provided chronically disease education by at least one format |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Record format education was provided via (fair, Sr Center etc) |  |  | In-person education given on coronary artery disease to Civitan group & 1st Course (approx. 300 attended) | Radio show (KWBW) interview/education covering CAD, PAD, diet & exercise information | Soroptimist health fair (medication, smoking cessation, COPD) approx. 75 served) |  |  |  |  |  |  |  |  |
| % of CHF pts dismissed from hospital that recd a post discharge call | Position was eliminated |  |  |  |  |  |  |  |  |  |  |  |  |
| % of new diagnosed CHF pts referred to the Community Care program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CHF patients received CHF education while in hospital | 50% |  |  |  |  |  |  |  | 80% | 52% | 64% | 71% | 100% |
| # of CHF patients accepted in the CC program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CHF readmissions (per ClinView database) |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Metric 1.1 | Benchmark | Jan 2021 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| # of Community member provided chronically disease education by at least one format |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Record format education was provided via (fair, Sr Center etc) |  |  | In-person education given on physical exercise to Civitan group (approx. 50 attended) | Radio show (KWBW) interview/education covering COVID/CAD, diet & exercise information |  |  |  |  |  |  |  |  |  |
| % of new diagnosed CHF pts referred to the Community Care program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CHF patients received CHF education while in hospital | 50% | 25% | 28% | 70% | 85% | 100% | 75% | 100% | 100% | 100% | 100% | 83% | 75% |
| # of CHF patients accepted in the CC program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CHF readmissions (per ClinView database) |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Metric 1.1 | Benchmark | Jan 2022 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| # of Community member provided chronically disease education by at least one format |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Record format education was provided via (fair, Sr Center etc) |  |  | In-person pacemaker education given to Civitan group (approx. 50 attended) |  |  |  |  |  |  |  |  |  |  |
| % of new diagnosed CHF pts referred to the Community Care program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CHF patients received CHF education while in hospital | 75% | 100% |  |  |  |  |  |  |  |  |  |  |  |
| # of CHF patients accepted in the CC program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of CC program patients that did not readmit in 30 days |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of CHF readmissions (per ClinView database) |  |  |  |  |  |  |  |  |  |  |  |  |  |

**NOTES**

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| Facility | Date | Notes | |
|  | Jan 2020 | Readmissions task group minutes: CHF order sets will determine our focus group   * Will send at least every other week email to group on updates of progress * Bring denial team member in to discuss financial impact on denials for CHF patients   Set a goal of readmits from 27% to 24% | |
|  | Feb 2020 | CHF order set completed 2/11, must got to MEC   * CHF Readmits in 30 days for month of December was 16.7%. * 7 day readmits were 5.6% * Rhonda and Katie are working on the standardized CHF education. No completion date set at this time. * Pharmacy will be concentrating on the discharge medication reconciliation for all CHF patients once order set in place. The order set will task them as a consult. Pharmacists are going through a 2-part education series. Roger also provided info on where to find cost of medications for pt in Cerner (such as if drug is tier or formulary) | |
|  | March 2020 | Follow up made with Erin Korb, Hutch Clinic’s Care Navigation (chronic condition program). They are starting this week by sending letters to their patients to enroll them   * Nicole reports John is currently working on building the updated CHF order set in Cert. Once this is approved it will move into Prod. There has been a task set up to send the pharmacists a notification that counseling is require. | |
| HRMC | June 2020 | 6/16 HRMC - CHF order set has been approved and beginning to be used in the hospital. The order set has a Day 2 task to consult dietary, Cardiac rehab and pharmacy for education in the hospital. Care Mgmt will monitor CHF patients and consult the Community Care program for supportive care in the home for up to 30 days s/p discharge. The hospital is paying for the charge for this program. Care Mgmt will meet with the patient prior to discharge and review POC and then f/u with a call s/p discharge to ensure the POC is working and provide any additional information needed.   * CHF order set available in place but not being utilized much. Lori Bortzfield is checking with the hospitalist group to see what barriers exist for using them. Noted that the order set is only being used for CHF primary dx. Aubrey working on report so we can tell how often order sets are being used. | |
|  | July | Pharmacy piloting a program to add pharmacist in ED & 5300 to help with med rec to decrease medication rec errors   * CHF order set used 10 times the month of June and 6 times during first part of July. * Jarrod reports our data shows we keep CHF patients ½ day shorter compared to the GMLOS. CC patients are 1.0 day shorter with a readmission rate of 25%. * Most readmits are occurring within 15 days of discharge.   CHF readmits volume so small so difficult to make a big impact. If we decrease one CHF readmit a month then we will fall below 20%. CHF order set working well for tasking and education. | |
| HRMC | August | 8/20 HRMC – Finalizing CHF order set for use. HRMC created program for those that are un-insured to provide 30 day f/u for education and assessments in the home, will also be calling at 24 and 72 hours to ensure the POC is meeting the pt needs.   * In July, order set used 9 times and so far in August it has been used 3 times. * For 2020, there have been 24 out of 81 CHF patients readmitted * Readmit rate through May was 28% * Hutch Clinic starting “population health”. Once this is up and running, Lori will follow up to see what program offers and if there are opportunities to partner * Prairie Star – no program we are aware of but reported they are willing to collaborate with the hospital   Home Care of Reno County – they have Community Care program but this is only for patients who would not qualify for home health. It was explained most patients have home health benefit and quality so that is offered more than the Community Care | |
| HRMC | Sept 2020 | 9/17 HRMC – Use of the CHF order set has been variable. Determined some issues: Changed the title to decrease confusion as to how it can be used. Working with the HRN to determine further issues on work flow for the order set. Establishing a process to review every case for order set was not used. Continue to review every readmission for CHF for opportunities in improvement of care.   * Discussion held on discharge medication list and physician instructions not being printed on the sheet. These instructions will only print if they were documented in the “note box” and not “special instructions” * Physician instructions has to be placed in the “ERX to Pharmacy” in order for the patient’s retail pharmacy to view them | |
| HRMC | Oct 2020 | 10/15- Name of CHF order set changed to remove the word “Admission”. However, it was realized the query was now not pulling pt data to report. Working with IT to correct. Aubrey finalizing CHF Bootcamp proposal to present to foundation for funding.   * CHF order set being used more frequently * New focus with Readmission Task Force: will be looking at 7 day readmits, regardless of diagnosis * Kim will send weekly list to taskforce group so close to real time situations can be assessed, looking for trends and opportunities to prevent readmissions | |
| HRMC | Nov 2020 | 11/19- CHF order sets and education are being used and provided. Grant for CHF boot camp was not able to get on Nov. Foundation meeting, will present in January.  2 out of 4 patients appear that readmission had opportunities that may have lowered risk of readmission:   * Home medication not restarted   Patient non-compliant with physician recommendations   * Discussion held around home medication list and process to verify including importance of reviewing home meds prior to dc. * If doctor wants a med ordered at dc’d, it can be ordered prior to dismissal and not activated until day of discharge. * Per sw assessments on readmissions, patients are voicing they received education on their disease prior to discharge, did pick up new prescriptions and saw pcp for f/u. | |
| HRMC | Dec 2020 | Meeting cancelled due to high volume of COVID patients at HRMC | |
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| HRMC | Jan 2021 | Order sets and education are being used and provided. In review of the 7 day readmits no issues with these two factors have been determined. HRMC Foundation approved a grant for the CHF Boot Camp, it is with Compliance now   * Current readmission rate: 13% for all dx and 19% for CHF | |
| HRMC | Feb 2021 | CHF Boot Camp is still with Counsel, cardiac rehab continues to provide CHF education to patients in hospital & working with hospitalists identifying patients in need of education, reviewing 7-day hospital readmissions. HRMC readmissions task group reviews  Discussed Med to Bed program and if this is something we can explore. Nicole states this has been looked into and the only way to set this up is to either be a retail pharmacy or distribute medications at no cost. | |
| HRMC | March 2021 | Pharmacists in ED, ICU, & 5 th floor. HRMC added 2 med rec pharmacy techs to verification of medication rec to decrease admission medication rec errors. Discharge medication education provided by pharmacist M-F  Starting March 29th, multi-disciplinary rounding will begin and this may help pharmacy and nursing with providing the dc education prior to patient leaving.   * 7-day readmits reviewed. Majority of these patients were discharged from first visit to a snf or home w/home health. * No specific trends or missed opportunities noted from these 7-day readmits.   Discussion held on post covid patients and if there will be any trends. This will be something to follow and monitor. | |
|  | April 2021 | * New pilot program getting ready to start on 5100 – nurse navigator. Role will be to help with admissions, discharges and on-going education through the patient’s stay.   Education material at discharge is being formatted by IS to include all education relative to patient dx, in easy to read/understand format   * 10 patients reviewed: no overall trends found. * Some had multi-factors/complex medical needs   All met goals of care at initial discharge   * **30-day readmission rate YTD: 14.2%** Target goal: 15.3% * **CHF 30-day readmission rate YTD: 23.3%** Target goal: 21.7% * **COPD 30-day readmission rate YTD: 11.4%** Target goal: 19.6% | |
| HRMC | May 2021 | CHF Boot Camp only available to indigent patients due to compliance regs start July 1. Continued monitoring of CHF patient education and readmissions. | |
|  | June 2021 | **Current data:**   * **30-day readmission rate: 10.7%** Target goal: 15.3% * **CHF 30-day readmission rate: 12.3%** Target goal: 21.7% * **COPD 30-day readmission rate: 7.1%** Target goal: 19.6% * Update on 5100 Nurse Navigator: working very well when fully staffed and not having to pull her to the floor. Nurse navigator has been focusing on admission and discharge of patients with on-going daily education, targeting CVA and CHF patients * Education discharge material reformatted by IS update: education material has been put in same place so easier to find. Medication education not being printed out with discharge instructions. | |
|  | July 2021 | EMAIL readmission meeting- 7-day readmits for review. No specific trends reported at this time.   * **30-day readmission rate: 10.3%** Target goal: 15.3% * **CHF 30-day readmission rate: 33.3%** Target goal: 21.7%   **COPD 30-day readmission rate: 25.0%** Target goal: 19.6% | |
|  | Aug 2021 | * Pharmacy is looking at options to help cover cost of medications for indigent patients, specifically the foundation * Pharmacy and care management can give approval to dispense medication at no-cost to patient if it is under $200.00   Some high-cost meds that are tasking care management and pharmacy are not getting addressed with patient prior to discharge to ensure they are able to afford it – education reminder needed.   * F/U appointments are not always being made for patient, especially if there isn’t a unit clerk. * Length of time on phone to make appointment can be time consuming * Lori B will reach out to Hutch Clinic liaison to see if they can assist to ensure appointments are being made   Care management can assist if staffing/time allows   * CHF order set is usually being used on admission and not after arrival. Discussion held on getting order set to be used whenever it is appropriate during course of patient’s stay. Discussion held on no pharmacy being listed on patient’s profile. If it is not listed it will go into default and prescription will not go through to fax.   Karla will look into changing default so pharmacy has to be listed prior to medication being prescribed.   * **30-day readmission rate: 10.3%** Target goal: 15.3% * **CHF 30-day readmission rate: 33.0%** Target goal: 21.7% * **COPD 30-day readmission rate: 25.0%** Target goal: 19.6% | |
|  | Sept 2021 | * Care management and pharmacy are now able to authorize filing discharge medications for patients who do not have access to obtaining medications d/t no pharmacy open, indigent, etc. This is a case by case basis and when all other options have been exhausted. * Most of 7-day readmits were set up with either home health or went to a nursing facility. * Majority were able to get medications filled and if enough time lapsed between admissions were able to see their pcp. * **30-day readmission rate: 10.4%** Target goal: 15.3% * **CHF 30-day readmission rate: 25.0%** Target goal: 21.7% * **COPD 30-day readmission rate: 33.3%** Target goal: 19.6% | |
|  | OCT 2021 | * Hutch Clinic has hired a new liaison, She will start in November and will provide post-discharge follow up phone calls and assist with getting patients scheduled to see pcp.   Prairie Star is providing post-discharge f/u calls to patient. They are getting patients into pcp approx. 2 weeks after hospital discharge but will schedule sooner per hospital request.  Tele-monitor consult for all CHF/COPD patients still being looked into. Determining who the task goes to, who oversees the monitoring and which patients would be appropriate is still undecided. Hospitalist and cardiology are getting ready to start-up sub-committee to discuss CHF protocol, order sets and if any areas need revamping.  7-day readmits reviewed. No specific trends/opportunities found   * **30-day readmission rate: 10.1%** Target goal: 15.3% * **CHF 30-day readmission rate: 17.1%** Target goal: 21.7% * **COPD 30-day readmission rate: 16.7%** Target goal: 19.6% | |
|  | Jan 2022 | * 7-day readmits reviewed. Noted some were due to patient being non-compliant * There was no trend based on which nursing facility, home health agency patient had at discharge, or if they were discharged home without services. Noted 10 out of 18 readmits did receive either home health or placement at first discharge. * For now, will continue to focus on 7-day readmits since this is an area where we can have most impact. * Pulmonary rehab being auto-consulted for pneumonia, asthma and COPD order sets. There is benefit in patients having this service at discharge so would like to see number in referrals increase.   CHF order set – workflow process.   * **30-day readmission rate: 10.2%** Target goal: 15.3% * **CHF 30-day readmission rate: 18.7%** Target goal: 21.7% * **COPD 30-day readmission rate: 20%** Target goal: 19.6% | |
|  | Mar 2022 | **Current data:**   * **30-day readmission rate: 8.4%** Target goal: 15.6% * **COPD 30-day readmission rate: 50%** Target goal: 19.7% * **AMI 30-day readmission rate: 6.3%** Target goal: 15.8% * **HF 30-day readmission rate: 0.0%** Target goal: 21.9% |
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| Objective 1.2: Increase the proportion of chronically ill residents receiving the appropriate vaccinations. | | | |
| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 1.2.1: Participate in the state-wide initiative on tracking all vaccinations through the state WebIZ that are provided by the Clinical CHIP organizations | July 2020 – March 2021 | Clinical CHIP members | HRMC  Hutch Clinic  Prairie Star  Summit  RCHD  Long Term Care Facilities |
| Strategy 1.2.2: Develop infrastructure to post and retrieve information from Web IZ | July 2020 – March 2021 | Clinical CHIP members | HRMC  Hutch Clinic  Prairie Star  Summit  RCHD  Long Term Care Facilities |
| Strategy 1.2.3: Provide, track and trend patients with a chronic illness an develop mechanisms to ensure vaccinations are appropriate, i.e. Influenza, Pneumo Vac, Prevenar, Hepatitis, Tetanus | 2021 | Clinical CHIP | HRMC  Hutch Clinic  Prairie Star  Summit  RCHD  Long Term Care Facilities |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * Number of Clinical CHIP members that are able to submit to retrieve information from WebIZ |
| *Outcome Indicators* |
| * Number of Clinical CHIP members that retrieve vaccine information from the State WebIZ site. |

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| Metric 1.2 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Number of CHIP members with established programs to submit and retrieve information from WebIZ | HRMC  Hutch Clinic  Prairie Star  RCHD |  |  |  |  |  |  |  |  |  |  |  |  |

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| Facility | Date | Notes |
| HRMC | June 2020 | 6/16 HRMC - HRMC Web IZ is established in EMR, still waiting on testing and confirmation from WebIZ on flow of information to and from. HRMC working on an auto abstraction of patients that meet the criteria for influenza and PNE vac and determine what % are actually getting the vaccinations that are required for their age. HRMC = Initial thoughts of having a program that would provide education to the patient of key Health Preventive tests that are needed for their age or diagnoses. |
| HRMC | Sept 2020 | 9/17 HRMC – Vaccinations for the chronically ill will start by developing a process to get vaccinations provided to appropriate age groups and meeting state requirements of logging the vaccinations that are given in the state WebIZ program. |
| HRMC | Oct 2020 |  |
| HRMC | Nov 2020 | 11/19- Mickey reported the progress on being able to submit vaccinations to Ks WebIZ. We have two EMR products that are needing to submit. We are submitting data from both but we have identified an error that Cerner is needing to address. Once that is resolved, we should be ready to actually test with WebIZ, if that goes well we will be able to activate the program. This will include vaccinations from July 2020 through current date and going forward. |
| HRMC | Dec 2020 | Meeting cancelled due to high volume of COVID patients at HRMC |
| HRMC | Jan 2021 | Started giving COVID vaccines to staff in December, continuing to submit data to WebIZ, working out IT issues |
| HRMC | Feb 2021 | Continued to give COVID vaccines to staff members, and working with RCHD, PrairieStar, Hutch Clinic |
| HRMC | Mar 2021 | Partnering with RCHD, PrairieStar, Hutch Clinic to give COVID vaccines to staff members. Volunteering w/ RCHD giving public COVID vaccines. |

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| Goal 3: Reduce the opioid impact on Reno County |
| Objective 3.1: Decrease the opioid prescribing by 20% |

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| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 3.1.1: Develop data collection methods to monitor opioid prescribing | July 2020 – December 2020 | Clinical CHIP | HRMC  Hutch Clinic  Prairie Star  Summit |
| Strategy 3.1.2: Develop methods to assess KTRACs prior to each opioid script that is written | July 2020 – December 2020 | Clinical CHIP | HRMC  Hutch Clinic  Prairie Star  Summit |
| Strategy 3.1.3: Provide education to providers on alternatives for pain management | July 2020 – June 2021 | Clinical CHIP | HRMC  Hutch Clinic  Prairie Star  Summit |
| Strategy 3.1.4: Provide education and medication management to Community Care patients following discharge from HRMC | July 2020 – June 2021 | Community Care Clinical Liaison | HRMC  HORC |
| Strategy 3.1.5: Grant for writing the program to abstract opioid data from the Cerner EMR at the hospital | July 2020 – Dec 2020 | Jarrod Urban | HRMC |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * Improve understanding of prescribing options for pain management through number of interactions with KTRACs * Improve understanding of prescribing options for pain management through number of practitioners attendance to education programs * Development of standardized opioid education materials for use in Community Care program * Improve the monitoring of opioid impact to the patient population served at HRMC |
| *Outcome Indicators* |
| * Decrease opioid prescribing in healthcare facilities * Number of Community Care patients whose opioid risk is assessed * Development of an Opioid dashboard for HRMC |

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| Metric 3.1 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| % of opioid scripts that have a KTRAC review prior to giving to patient |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of opioid meds on the home med list |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of opioid meds on the discharge med list |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of decrease in opioid meds between home and discharge med list |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Facility | Date | Notes |
| HRMC | June 2020 | Application for a grant through KHC granted to pay for programing of dashboard from HRMC EMR related to Opioid metrics |
|  | Sept 2020 | Grant for the abstraction program within the hospital EMR has been completed and the program is allowing a new evaluation of opioid prescribing and management from the acute setting. Currently we have determined that we have given more Narcan than we did in all of 2019. We have determined that we have had at least 8 overdoses (although the feeling is that we have had more but the coding at discharge was under a different DRG). Working on assessment of the number of opioids are on the Home Med List and the number that are on the Discharge Med List. Second focus for this next month will be on investigations into Adverse Drug Events. |
|  | Nov 2020 | Beginning to get some consistent data from the EMR in the hospital. The Opioid Stewardship Committee will review the data for opportunities and will be also looking at the volume of scripts sent home with opioids. Continuing to work on practitioner access to KTRACS prior to writing an Opioid Scripts. |
|  | Jan 2021 | Ad-hoc meeting to discuss implementing SUDS contact info into our Discharge Education.  Recovery Response Team   * Funded by grant directed by Bureau of Justice Assistance for Rural Response to Opioid Epidemic * Partnership with Reno County Health Department * Based on notification by local health-care providers and community members, the Recovery Response Team’s mission is to respond to any overdose or relapse in Reno County within 24-48 hours of the event regardless of the substance involved * The goal is to quickly connect the community member and their family-system to resources that assist with treatment, increasing social capital, community capital, stable social/relational interactions and improved self-efficacy * Customized to the individual and their circumstances regardless of payor source and patient/client status within the HRMC system |
|  | FEB 2021 | Narcan Education, Kim will send out information for free Narcan and the education slides. CDC is recommending everyone carry Narcan and recognize over dose. Kim reported that Seth had mentioned there were about 60 by-standard Narcan given, but there is no record in OD tracking of this number. One item that was emphasized was when they call 911 just to say there was a person down, but not that you suspected an overdose. The team speculated that was due to preventing a police response. Review of Pain Management and Opioid Stewardship Dashboard. |
|  | JUL 2021 | MOSS (Michigan Opioid Safety Score) implemented in HRMC and built into HER, building report also on non-pharmacologic interventions  July 1, 2021- all narcotics must be prescribed electronically and can no longer be written on paper scripts in HRMC |
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|  | Oct 2021 |  |
|  | OCT 2021 | Reno County data |
|  | Mar  22 | Impact of Overdose – Narcan Training scheduled April 6th (Director Level) 2-4p at Doctor’s Park; April 19th (Staff Sessions Level) 9a, 12p, 5:30p at Pavilion |
|  |  | Review of Pain Management and Opioid Stewardship Dashboard – the past 12 months of data was available and appended to these minutes.    **Metrics –** Focused on January and February 2022 Jan 22 Feb 22  Pain Reassessed at least by next assessment 91% 90%  Effectiveness of pain management (Excludes OR) 91% 86%  Non-pharmacologic pain interventions (# of patients) 24 27  Lori and Jessica report that all ortho/joint patients get ice, and PT encourages ice to be moved prior to  administering narcotics  High Risk Screening task /assessment (MOSS) 647 565  -Number of 3 or 4 4 0  Discussion held on administering scheduled pain medications when patients have no pain, or pain rating does  not match the pain scale on the medication order. |
|  |  | Reassessment with in 30 or 60 minutes    Reassessment by next assessment    Effectiveness of Pain Management    Interventional Radiology Metrics |
|  |  | Narcan Administration    Dec 21 Jan 22  ODMAP (County Overdose) tracking 12 17  -Non-Fatal 12 17  -Fatal 0 0  -Narcan Administered (1 or more) 1 5  -EMS 0 0  -Fire 0 1  -Police 1 0  -Hospital 0 0  -Bystander 0 3  -Unknown 0 1  -Type of Drug Suspected  - Heroin 0 1  - Oxycodone 0 2  - Fentanyl 0 1  - Cocaine 0 1  -Prescription Drugs 1 6  - Methamphetamine 5 2  - Benzodiazepine 0 2  - Alcohol 3 5  - LSD 0 0  - OTC 1 2  - Synthetic Marijuana 0 0  - Other 2 2  -Gender  - Male 9 11  - Female 3 6  -Age Range 24-64 17-63  Reno County data is slightly different, and includes Coroner cases. |
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| Goal 2: Increase awareness of Smoking Cessation opportunities to the residents of Reno County |
| Objective 2.1: Provide a consistent message on smoking cessation |

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| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 2.1.1: Determine the options for smoking cessation. | April 2020 – March 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |
| Strategy 2.1.2: Develop an education tool for smoking cessation that meets the needs of the Clinical CHIP members | April 2020 – March 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |
| Strategy 2.1.4: Re-survey Clinical CHIP members regarding compliance with providing smoking cessation education to every smoker treated in their facilities | April 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * Develop methods to track number of patients with chronic respiratory disease patients hospitalized * Increase number of patients served through the Clinical CHIP member agencies that received smoking cessation education brochure * Increase the number of patients referred to the KAN-Quit program |
| *Outcome Indicators* |
| * Increase the % of practitioners that report they provided smoking cessations to the patients they cared for, via survey * Increase number of patients that complete the KAN-Quit program * Increase the number of Reno County residents that report they have quit smoking in the last 12 months through the CHNA next survey * Decrease the number of Reno County residents that report to have smoked a cigarette in the previous 12 months * Decrease the number of Reno County residents that used an e-cigarette in the previous 12 months. |

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| Metric 2.1 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| % of RC residents that completed the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents enrolled in the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents that completed the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| patients enrolled in the KAN-Quit program at HRMC |  |  |  |  |  |  |  | 1 | 0 | 0 | 1 | 3 | 0 |
| # of patients admitted to HRMC that smoke |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents with CRD hospitalized at HRMC |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # KanQuit lung cancer screening interverventions |  |  |  |  |  |  |  | 6 | 3 | 2 | 2 | 1 | 2 |
| HRMC in-patients that smoke that received smoking cessation education |  |  |  |  |  |  |  | 23 | 21 | 9 | 31 | 17 | 11 |
| % of Hutch Clinic patients that smoke that received smoking cessation education |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of Prairie Star patients that smoke that received smoking cessation education |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Metric 2.1 | Benchmark | Jan 2021 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| % of RC residents that completed the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents enrolled in the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents that completed the KAN-Quit program |  |  |  |  |  |  |  |  |  |  |  |  |  |
| patients enrolled in the KAN-Quit program at HRMC |  | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 |
| # of patients admitted to HRMC that smoke |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # of residents with CRD hospitalized at HRMC |  |  |  |  |  |  |  |  |  |  |  |  |  |
| # KanQuit lung cancer screening interverventions |  | 6 | 5 | 4 | 1 | 3 | 3 | 1 |  | 1 | 2 | 3 | 2 |
| HRMC in-patients that smoke that received smoking cessation education |  | 16 | 15 | 18 | 9 | 5 | 4 | 3 | 4 | 5 | 2 | 3 | 4 |
| % of Hutch Clinic patients that smoke that received smoking cessation education |  |  |  |  |  |  |  |  |  |  |  |  |  |
| % of Prairie Star patients that smoke that received smoking cessation education |  |  |  |  |  |  |  |  |  |  |  |  |  |

**NOTES**

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| Facility | Date | Notes |
|  | Jan 2020 | Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 |
| HRMC | June 2020 | Maurice is working on two processes to increase smoking cessation education to patients treated through HRMC. 1)setting up a trigger in Cerner to task the RT of a patient admitted that is a smoker. The RT will then provide smoking cessation and try to get them enrolled in KAN-Quit. 2) when patients arrive for the exam for the Lung Cancer Screening program, and are a smoker, RT will provide smoking cessation and KAN-Quit literature and enroll if agreeable. Issue currently is EMR tasking the RT. |
|  | 2019  data | HRMC Stroke patients receiving smoking cessation education 2019  Benchmark Group Time Period Numerator Denominator % of Patients  My Hospital 2019 22 22 100.0 |
|  |  |  |
|  | June 2020 | Published in the Resident Perception Drive Progress on Health in Reno County that 69% of respondents are aware of community efforts to promote smoking cessation. This compares to the last CHNA question which had 65% that were not aware of smoking cessation programs. |
|  | Aug 2020 | PS reported that enrolling in KAN-Quit is part of the EMR that documentation so that they can easily track their information. |
|  |  | Add smoking cessation education to the Joint Care Class |
|  |  | Discuss doing a community project for the November Third Thursday – “Great American Smoke Out” November 19 |
|  | Sept 2020 | 3/20 smoking cessation assessments signed up for KanQuit program.  Initial discussion on community event on Smoking Cessation for the Great American Smoke Out Day 11/19, possible coordinate with Third Thursday events downtown. |
|  | Nov 2020 | Community event was cancelled r/t to COVID. Alternate community action was getting the coffee shops to promote the Great American Smoke Out with coffee cup sleeves and stickers. Respiratory Therapist continue to work with patients on smoking cessation by promoting education and support through the KAN QUIT program. Past month worked with 32 patients and got 2 to sign up for the program |
|  | Jan 2021 | 61% of HRMC STEMI AMI patients received smoking cessation education for 2020 |
|  | 1/1/2020-6/30/2021 | 296 patients educated on smoking cessation in cardiac & pulmonary rehab, and ST-elevation myocardial infarction patients |
|  |  | Created “Tobacco cessation education” documentation in our electronic health record |
|  | Jan 2021 | HRMC Stroke patients receiving smoking cessation education 2020  Benchmark Group Time Period Numerator Denominator % of Patients  My Hospital 2019 22 22 100.0%  My Hospital 2020 15 15 100.0% |
|  |  | Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 |
|  | 4/15/2021 | RCHD provided KanQuit Education to HRMC respiratory services for patient referral/education |
|  | 5/5/2021 | RCHD provided KanQuit Education to HRMC cardiac and pulmonary rehab for patient referral/education |
|  | Dec 2021 | 85.7% HRMC STEMI AMI patients received smoking cessation education for 2021 (an increase of 24.7%) according to AHA-GWTG CAD data |
|  | Jan 2022 | Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 |
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|  | Jan  2022 | HRMC Stroke patients receiving smoking cessation education 2021  Benchmark Group Time Period Numerator Denominator % of Patients  My Hospital 2019 22 22 100.0%  My Hospital 2020 15 15 100.0%  My Hospital 2021 19 19 100.0%  Date of report: 03/24/2022 14:28:48 GMT-05:00 run by User: Julie Wiens (jwiens01) at Site: Hutchinson Regional Medical Center (75886)  Please note: GWTG aggregate comparative data is intended for internal quality improvement. Permission is required from the American Heart Association and Quintiles for  external presentation or publication of benchmark data. |

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| Objective 2.2: Increase attendance at smoking cessation classes for residents of Reno County | | | |
| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 2.2.1: Review the KAN-Quit program and other smoking cessation classes offered in Reno County | March 2020 – September 2020 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |
| Strategy 2.2.3: Conduct pilot KAN-Quit classes using employee groups from Clinical CHIP members | March 2020 - December 2020 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit RCHD |
| Strategy 2.2.4: Conduct four KAN-Quit classes in different areas of Reno County | 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit RCHD |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * Increase opportunities for smoking cessations classes in Reno County * Increase opportunities for businesses to support their employees in smoking cessation |
| *Outcome Indicators* |
| * Decrease the # of people reported to have smoked a cigarette in the previous 12 months * Decrease the # of people reported to have used an e-cigarette in the previous 12 months |

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| Metric 2.2 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Same as 2.1 |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Facility | Date | Notes |
| HRMC/RCHD | Nov 2020 | Group sessions have been put on hold r/t to group meeting restrictions. |
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| Objective 2.3: Develop a program that provides smoking cessation medication free or reduced cost to low income / marginally insured residents of Reno County | | | |
| Strategy | Timeframe | Responsibility | Potential Partners |
| Strategy 2.3.1: Research grants for program | March 2020 – April 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |
| Strategy 2.3.2: Develop a program utilizing smoking cessation classes supplemented by the use of medication | 2021 | Clinical CHIP members | KAN-Quit  RCHD  HRHS  Hutch Clinic  Prairie Star  Summit |

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| **Outcomes & Measures** |
| *Process Indicators* |
| * Increase number of grants applied for * Increase the dollars received from grants and fundraising to establish program assisting with tobacco cessation * Increase the number prescriptions for tobacco cessation |
| *Outcome Indicators* |
| * Provide optimal smoking cessation techniques to citizens of Reno County * Decrease the # of people reported to have smoked a cigarette in the previous 12 months * Decrease the # of people reported to have used an e-cigarette in the previous 12 months |

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| Metric 2.3 | Benchmark | Jan 2020 | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
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| Facility | Date | Notes |
| HRMC |  | Aubrey Nuss has spoke with a couple grant writers, and struggling to find grants that meet compliance criteria. HRMCs insurance meets ACA requirements and offers their employees tobacco cessation medications/aides. |
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