Best Practice for Standardizing Anticoagulation Education

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CHALLENGE
We had a lack of standardization of anticoagulation patient education across the clinic sites. Each clinic would offer different patient education materials, which demonstrated the lack of standardization across all of our sites.

PROCESS FOR CHANGE
Our goal was to standardize patient education and implement the education clinic-wide. We created a standard workflow to manage anticoagulation patients.

RESULTS
• Patients are receiving standardized care and education.
• A shared electronic resource drive that has all of the education information, best practice policies and protocols.

ADOPTION CONSIDERATIONS
• It was important that all education resources were compiled and that each clinic was using them to develop standard education practices.
• Since it was a policy and procedure change with the approval of the Nurse Practice & Policy Committee and the physician Best Practice Committee, there were no significant barriers.

RECOMMENDATIONS FOR SUSTAINING GAINS
• Implemented a shared electronic drive which will be updated as new information is acquired.
• Created an anticoagulation distribution email to disseminate information among anticoagulation nurses/sites.
Improving Colorectal Cancer Screening through EMR and Workflow Optimization

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CHALLENGE
Colorectal cancer (CRC) screening is a priority quality measure nationally and across our health system. The project’s purpose was to increase colorectal cancer screening rates by reducing structural barriers for patients, improving patient and provider reminder and recall systems, and provider assessment and feedback initiatives.

PROCESS FOR CHANGE
Clinic teams play an essential role in improving care coordination and quality care. Optimal EMR functionality is also an essential component of a successful CRC screening program. This project implemented a three-month CRC screening recall workflow pilot at eleven urban and rural clinics. The workflow included: identifying patients overdue for their CRC screening using the healthy planet reporting workbench report, sending recall letters or My Chart messages for CRC screenings, and following up with a phone call for patients who do not respond.

After the pilot, we updated the workflow so it could be implemented system-wide and we developed additional EMR functionality to support CRC screening.

RESULTS
• As of July 2017, ten of our primary care clinics are exceeding the 80 percent screening goal. As a system, our screening rate is 72.4 percent, or approximately 97,000 patients. This is an increase of over 14,000 patients receiving screenings since 2015.

• In collaboration with the South Dakota Comprehensive Cancer Control Program Colorectal Cancer Task Force, select clinics recently received the 80 percent by 2018 Organization of the Year Award.

ADOPTION CONSIDERATIONS
• EMR optimization is essential for identifying patients not meeting goals and developing outreach workflows.
• Team-based approach is more successful.

TAKING AIM AT AFFORDABILITY
• Data transparency.
• Offer preventive screening options at every clinic visit during the rooming process.
• Seek opportunities to partner with employee health to offer CRC screening options during flu shot clinics.
• Continue to identify care team members that can support CRC screening workflows in our different clinics.

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In 2015, Olmsted Medical Center (OMC) established a strategic goal to develop and implement a patient fall risk assessment and prevention program throughout the organization. The program’s purpose would be to identify patients at risk for falls, communicate this across departments, improve reporting of patient falls, and reduce the number of patient falls.

The Preventative Medicine Core Team developed a fall risk assessment process. This process included development of a form for better identification of patients 65 and older and those thought to be at high risk of a fall. The assessment is completed on these patients annually, or more often if a change in the patient’s medical condition occurs. If a patient is identified as high risk, the nurse will place a yellow band on their arm while they are in the organization. For returning patients, a designated OMC employee will place a new yellow band on the patient. This ensures the patient is transported safely from point A to point B.

The goal was to increase screening and identification of patients from the 2014 rate of 13.09 percent.

Results:
- 2016 screening rate: 77.70 percent.
- 2017 screening rate: 91.88 percent.

In response to patient feedback (refusal to wear band, staff not explaining band’s purpose, band’s low visibility), we began to use cards instead of bands in summer 2017, as well as provide additional education on the explanatory scripts prepared for designated OMC employees to read to patients.

Adoption Considerations:
- Recognize importance of training and education for staff and patients on the new process, as well as learning curves for the selected patient population.

Recommendations for Sustaining Goals:
- Frequent re-evaluation of the process and modifications as needed.
- Patient and staff input considerations.
Utilization of Electronic Health Record Tools to Improve Compliance in Lung Cancer Screening Requirements

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CHALLENGE
There were unprecedented compliance requirements for a new preventive care service that offered an opportunity for developing system tools to streamline and simplify screening processes across a large health system. Lung Cancer Screening with low-dose CT is recommended by the USPSTF and covered by private insurance and CMS. However, requirements extend far beyond the CT exam with exhaustive recommendations for pretest counseling, exam acquisition, imaging interpretation, result reporting and follow-up of findings. These additional requirements are obligatory for reimbursement but largely unknown to primary care providers. The challenge was to develop an easy-to-use tool that not only simplified screening initiation, but also addressed complex compliance requirements.

PROCESS FOR CHANGE
Although provider education was attempted through multiple means, ultimately education alone proved to be inadequate for changing behavior. Thus, electronic health record system tools were developed to educate and facilitate compliance. Two specific tools and electronic health record modifications were made: initially an EPIC SmartSet was created in January 2015; then an automatic substitution (Best Practice Alert) of SmartSet was implemented in August 2015 when screening orders were selected.

RESULTS
• Shared Decision Making rates improved after implementation of EHR tools.
• Smoking Cessation Assistance rates improved after implementation of EHR tools.

ADOPTION CONSIDERATIONS
• Barriers to compliance were considered: namely knowledge about requirements and tools to complete requirements.
• Integrated electronic health records provided a platform for uniform access to and utilization of tools.

RECOMMENDATIONS FOR SUSTAINING GOALS
• Provider feedback on tool functionality is ongoing both from individual providers as well as ambulatory leadership, including an informatics committee.
• Minor adjustments to optimize functionality occur as needed.

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Developing a Chronic Disease Management Model at HCMC Brooklyn Center Clinic to Standardize Clinic Processes in the Management of Patients with Chronic Illnesses

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CHALLENGE
We needed a standard process for chronic disease management to improve health outcomes. The project focused on improvement of diabetes care by increasing the number of patients meeting the A1C less than 8 percent criteria, defined by Minnesota Community Measurement (MNCM), as well as increasing the optimal D5 score by 3.5 percent. Additionally, the clinic desired a model that could be scaled up to all chronic disease management.

PROCESS FOR CHANGE
We identified the gaps in the current state of diabetes management, leading to the development and implementation of tests of change, which anchored successful tests of change within our workflows to improve patient care. The workflow adopted for diabetes was later scaled up to asthma care with similarly successful outcomes.

RESULTS
• Improved care delivery for patients with diabetes and asthma.
• Increased patient, staff, and physician satisfaction.
• Excitement and energy from clinical staff members engaged in quality improvement activities.

ADOPTION CONSIDERATIONS
• Involve frontline staff members and test out their ideas.
• Adopt rigorous data processes to assess impact.
• Be proactive rather than reactive in condition assessments and scheduling designated PCP visits to discuss asthma and diabetes care.

RECOMMENDATIONS FOR SUSTAINING GOALS
• Seek input directly from front line staff and conduct tests of change based on their suggestions to determine whether the process needs to be adopted, adapted, or to start a different process.
• Utilize data tools to quantitatively assess the impact of the work.
• Focus on anchoring workflows and committing to processes even if outcomes are not improving as fast as the process implementation.
• Communicate information and data in a variety of ways to all staff members and ensure the information is presented in a simple way.
Preoperative Medical Management to Prevent Complications in Patients Undergoing Hip and Knee Replacement Surgery

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CHALLENGE
Our hospital was experiencing preventable complications for joint replacement patients, which negatively affects patient experience and value of care.

PROCESS FOR CHANGE
Our process was to identify potential complication risks earlier in the pre-operative time period with the goal of reducing complications and improving patient experience. An interdisciplinary team developed a two-stage review of patients’ History & Physical forms (H&Ps) prior to surgery. The H&P review process changed from one to two days before surgery to a goal of at least 14 days, and included a new handoff process to a Nurse Practitioner (NP) for patients flagged for potential complications. The NP then coordinated care decisions between the patient and care team for all risks identified before the joint replacement surgery.

RESULTS
• Flagged 72 of 218 patients for increased medical risk of complications and NP review.
• 154 medical flags were identified for 72 patients, ranging from one to four flags per patient.
• NP chart reviews averaged 60 minutes, ranging from 10 to 240 minutes.
• Avoided 13 possible day-of surgery cancellations.
• Six surgery cancellations due to medical risk outweighing the benefit of the surgery.
• Surgery cancellations within zero to four days reduced from three patients/month to one patient/month.
• One of 218 patients experienced a complication during the three month pilot.
• Complication rates dropped from an expected 1.8 patients/month to 0.33 patients/month.

ADOPTION CONSIDERATIONS
• Implement a process to review H&Ps well before scheduled, elective procedures.
• Have an operational structure in place for an initial and secondary screen, involving the patient and the surgeon in decision making.
• All care team members and the patient need to have a baseline goal to reduce preventable complications.

RECOMMENDATIONS FOR SUSTAINING GOALS
Hire an additional NP to support each hospital to proactively decrease complications and improve patient experiences.

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