

## Hard Work is Paying Off

The three great essentials to achieve anything worthwhile are, first, hard work;  
second, stick-to-itiveness; third, common sense.

-- Thomas Edison

Hard work, stick-to-itiveness and common sense define the Omaha CareTrek community. Task-oriented groups continue to work to decrease the gaps in care transitions and it seems that everyone is aware and working towards reducing readmissions. Thank you for your hard work and commitment.

The home health community developed a "wish list" for medication management. Some of their wishes are easy, like including the generic and brand name of medications; some of their wishes are hard, like community-wide standardization of a medication list. If you send patients to homecare agencies, review this list (*included inside*) and see if you can help.

Skilled nursing facilities are working to define a similar list that may be helpful for electronic transfer sheets. This group is exploring what information can be sent directly from a hospital's electronic health record without going through the tedious task of handwriting information. We will share their information as it is developed.

Every hospital in the CareTrek community is working on avoidable readmissions. Some are participating in the H2H (Hospital to Home) campaign to improve cardiovascular care; others are standardizing their discharge instructions and all are working on medication reconciliation. We appreciate the time and stick-to-itiveness they have demonstrated.

We still need to work on getting patients to make and keep appointments with their outpatient providers - physician, PA or APRN. This visit is an opportunity to review the medication list and to help evaluate for early warning signs of instability that might lead to readmission.

Here's how you can participate:

1. Enroll in the AHRQ Implementing Medication Reconciliation and Management Collaborative (*additional details inside*)
2. Continue the Coleman model of coaching\*
3. Attend CIMRO of Nebraska's Healthcare Quality Forum on May 11, to learn about the many quality improvement projects taking place across the state (*additional details inside*)
4. Help each patient to schedule an outpatient follow-up appointment upon discharge

The processes are being developed to reduce avoidable hospital readmissions. CareTrek community partners have great common sense, a stick-to-it attitude and are willing to do hard work. Thank you again for your commitment to this project.



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### The Trek ...

Welcome to the fifth issue of *The Trek*. The purpose of this newsletter is to keep you informed of the progress of CareTrek and topics relating to improving transitions of care. Visit [www.cimronebraska.org/caretrek.aspx](http://www.cimronebraska.org/caretrek.aspx) for additional information, including resources, tools and links.

If you wish to be added to the distribution list, visit [www.cimronebraska.org](http://www.cimronebraska.org) and click on "Join our E-mail List". Select "CareTrek Mailing List" on the CIMRO of Nebraska Mailing List Sign-up Form.



CareTrek™  
A CIMRO of Nebraska Care Transitions Project

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# Implementing Medication Reconciliation and Management: A New CareTrek Learning Collaborative

As part of CareTrek, CIMRO of Nebraska is pleased to offer the opportunity to participate in an Agency for Healthcare Research and Quality (AHRQ) learning collaborative focused on medication reconciliation and management. This invitation is being extended to all CareTrek partners, including hospitals, homecare agencies, skilled nursing facilities, pharmacies, dialysis centers and physician offices.

The AHRQ QIO Learning Network's "Improvement in Medication Reconciliation and Management" project is an accelerated improvement collaborative that will offer face-to-face learning sessions with leading subject experts and technical support from quality improvement professionals. The program focuses on five areas to facilitate improvement of medication reconciliation and management:

- 1 Assessment of current practice
- 2 Integration of tools and resources
- 3 Staff training and development
- 4 Patient/caregiver teaching and training
- 5 Measurement of interventions

The New York Quality Improvement Organization, IPRO, is coordinating efforts of the AHRQ's Learning Network. Participation will augment current quality improvement efforts to prevent medication errors and improve patient safety. Organizations electing to participate in the Learning Network agree to take part in an accelerated learning collaborative facilitated by IPRO, which includes: two face-to-face learning sessions, biweekly support teleconference calls, Web conferences and an opportunity to participate in an online forum for sharing best practices.

Participating providers also agree to collect run chart data, and at the end of the collaborative to work with IPRO and CIMRO of Nebraska leaders to develop a case study summary to describe the experience and success of participation in the project. One-on-one technical assistance will be provided as needed.

Participation is free of charge. The first Nebraska training session is scheduled for Tuesday, April 13, 2010, at the Thompson Center in Omaha. This collaborative will conclude in September 2010. Additional details will be sent soon.

We hope you take advantage of this unique opportunity to incorporate AHRQ's proven strategies into your quality improvement processes. The CareTrek team looks forward to working with you and your team on this collaborative and supporting your participation in this effort.



## Studies have shown:

- Up to 27% of all hospital prescribing errors can be attributed to incomplete medication histories at the time of admission.

Dobrzanski S, Hammond I, Khan G, et al. The nature of hospital prescribing errors. *Br J Clin Govern* 2002;7:187-93

- 33% of patients discharged from the ICU had one or more of their chronic medications omitted at hospital discharge.

Bell CM, Rahimi-Darabad P, Orner AI. Discontinuity of Chronic Medications in Patients Discharged from the Intensive Care Unit. *J Gen Intern Med* 2006;21:937-941

- 22% of medication discrepancies could have resulted in patient harm during their hospitalization and 59% of the discrepancies could have resulted in patient harm if the discrepancy continued after discharge.

Sullivan C, Gleason KM, Groszek JM, et al. Medication Reconciliation in the Acute Care Setting, Opportunity and Challenge for Nursing. *J Nurs Care Qual* 2005;20:95-98.

**If you have questions about participating in this collaborative, contact Paula Sitzman, RN, BSN, CIMRO of Nebraska Quality Improvement Advisor, at 402-476-1399 or via e-mail at [psitzman@neqio.sdps.org](mailto:psitzman@neqio.sdps.org).**

# Successful Outcomes of Medication Management

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Over the past year, CareTrek has brought together healthcare providers, stakeholders and community organizations to develop and implement intervention plans to reduce rehospitalization among Medicare beneficiaries residing in Douglas and Sarpy counties.

Hospital discharge teams and homecare staff met as a community learning group in late January 2010. The goals of the group are to: 1) improve the sender/receiver communication between the hospital discharge teams and homecare; and 2) improve medication reconciliation within the Omaha-area community. The purpose of the January session was to discuss the patient discharge process and identify ways to improve the communication exchange, specifically related to the hand off of the medication list.

The list of recommendations follows:

1. On the discharge medication list, include the following key elements:
  - a. all medications the patient was taking at discharge, regardless of administration method
  - b. brand and generic name for each medication
  - c. indication for use
  - d. where and/or how it is to be administered
  - e. time last dose was given at the discharging facility
2. On the discharge instructions, include a contact phone number from the discharging institution for questions. This may be the case manager and/or discharge planner.
3. At discharge, send signed paper prescriptions with the patient for all medications to allow for timely refills at the patient's current pharmacy choice.
4. Include lab results on the transfer sheet if appropriate, such as with Coumadin and IV antibiotics.
5. Automatically include the time and date the medication list was last updated.
6. Hospital discharge information, including current medication list should be sent to the primary care physician and specialist, as well as the post-acute care facility or agency.
7. Access to real-time electronic health record information for each patient.
8. Automatic receipt of the hospital discharge summary when available.
9. Community-wide standardization of the content of the current medication lists across the continuum of care and from all provider settings.
10. Electronic version of current medication list.

## Improving Care Transitions And Reducing Hospital Readmissions:

*Establishing The Evidence For Community-Based Implementation Strategies Through The Care Transitions Theme*

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The care transitions work of communities across the nation is making national headlines. The January/February 2010 publication of *The Remington Report* offers a comprehensive look into the problem of hospital readmissions and the innovative work being done in the 14 communities to improve the care transmission experience for patients and to reduce avoidable rehospitalizations.

To access the article, visit [http://www.cfm.org/caretransitions/files/Care\\_Transition\\_Article\\_Remington\\_Report\\_Jan\\_2010.pdf](http://www.cfm.org/caretransitions/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf).

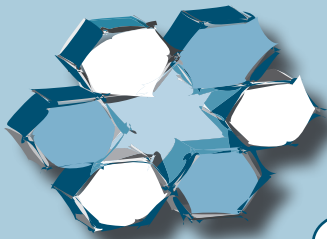
# CIMRO of Nebraska Awarded HIT Regional Extension Center Cooperative Agreement

CIMRO of Nebraska is pleased to introduce Wide River Technology Extension Center (Wide River TEC) as Nebraska's Regional Extension Center for Health Information Technology (HIT). Regional Extension Centers were established as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. \$6.6 million was awarded to CIMRO of Nebraska as a four-year cooperative agreement grant from The Office of the National Coordinator for Health Information Technology (ONCHIT) to establish Wide River TEC to assist Nebraska healthcare providers with implementing and using Electronic Health Records (EHRs).



Wide River TEC will offer technical assistance, guidance and information on best practices to support and accelerate healthcare providers' efforts to become meaningful users of EHRs, as well as the ability to exchange health information with other providers and agencies. Wide River TEC services will be available to all healthcare providers in the state, including those who already have an EHR in place.

Efforts to establish Wide River TEC as a distinct business unit within the CIMRO of Nebraska corporation are underway. CIMRO of Nebraska will be contacting eligible physicians and providers in the near future. **Visit [www.widerivertec.org](http://www.widerivertec.org) to be added to the Wide River TEC distribution list to receive information on the launch and progress of the organization.**



6.0 CEUs available  
pending approval

## Nebraska Healthcare Quality Forum Tuesday, May 11, 2010 Omaha - La Vista Embassy Suites Register Now!

Visit [www.cimronebraska.org/qualityforum.aspx](http://www.cimronebraska.org/qualityforum.aspx)  
to register and for additional details.

Questions? Keri McDermott, Communications Director, via phone, at 402-476-1399 or e-mail at [kmcdermott@neqio.sdps.org](mailto:kmcdermott@neqio.sdps.org)

## Patient Safety Awareness Week - March 7 – 13, 2010

Patient Safety Awareness Week (PSAW) is a national education and awareness building campaign for improving patient safety at the local level. Hospitals and healthcare organizations are encouraged to plan events to promote patient safety within their own organizations. Educational activities are centered on incorporating patients and families as active participants on their healthcare teams, as well as assisting organizations to build partnerships within their communities.

The cornerstone of the 2010 PSAW week is COMMUNICATION – the foundation for safe, effective, efficient equitable and timely healthcare. The areas of focus are 1) healthcare-associated infections and 2) getting the right diagnosis.

The National Patient Safety Foundation has developed a list of suggested activities to consider implementing. Resources include buttons, posters, patient safety specific activities, patient and family engagement tools and best practice guidelines and templates. For more information and access to these resources, visit <http://www.npsf.org/hp/psaw/>.

**For questions or suggestions for future publications, contact Keri McDermott,  
CIMRO of Nebraska Communications Director, at 402-476-1399 or via e-mail at [kmcdermott@neqio.sdps.org](mailto:kmcdermott@neqio.sdps.org).**