

The Trek

CIMRO of Nebraska's Care Transitions Project newsletter

Issue 3
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Good things happening in Omaha...

We are pleased with the commitment and energy that has been put forth by Omaha healthcare providers to improve transitions of care. Good things are happening throughout the Omaha area and we are excited to be part of it.

The CareTrek team continues to offer technical assistance and resources to support current efforts. We see ourselves as the 'link' between providers and best practices. It is our hope, through our collective work and partnerships, that we will be successful in meeting our mission – to lower the rate of hospital readmissions in Douglas and Sarpy Counties through improved care transitions.

This issue of *The Trek* focuses on some of the quality improvement efforts that currently are underway in the Omaha community. Congratulations on your hard work! In addition, we have included information about resources that are available to you, free-of-charge, from the National Network/National Libraries of Medicine. This includes links to information about medication reconciliation and patient education.

We want to continue to spotlight the many good things being done. For those working to improve care transitions within your organization, please share with us your approaches and goals. We look forward to sharing continued successes as we forge ahead.

Thanks again for your participation and commitment to this important initiative.



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The Trek...

Welcome to the third 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 for additional information, including resources, tools and links.

If you wish to be added to the distribution list, visit 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.

For questions regarding this publication, contact Keri McDermott, CIMRO of Nebraska Communications Director, at 800-458-4262 or via e-mail at kmcdermott@neqio.sdps.org.

Spotlight on CareTrek

Two organizations are highlighted in this issue of *The Trek*.

Read the articles on page 2 & 3.



CareTrek™

A CIMRO of Nebraska Care Transitions Project

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Spotlight on Alegent Health

By Janis Opperman, RN ~ Operations Director for Quality Management

Streamlining Processes and Improving Patient Care

Alegent Health is always looking for ways to streamline our processes and improve patient care as we continue on the path of fulfilling our mission to provide the highest quality of care for our community. Through CareTrek, Alegent Health is working to improve our patient experience through improved care transitions. Medicare data has identified the common thread on all hospital readmissions is related to medication issues. This information put more emphasis on accuracy and clarity of discharge medication reconciliation.

Over the last three years, Alegent Health has chartered a variety of teams to address the difficulties related to medication reconciliation and patient information at discharge. Alegent Health has trialed pharmacists doing discharge medication reconciliation. This effort was well received by nursing staff, but scheduling was very difficult with the unpredictable schedules and the quickness of patient discharge. We also implemented a nursing double check on all medication reconciliation and made changes to improve clarity of data entry. An internal training session focusing on the importance and process of medication reconciliation was held with staff as the method was trialed. While there were improvements made with each method, the accuracy scores indicated there was opportunity for improvement.

We then conducted a Failure Mode Effect Analysis and determined the greatest opportunity to impact the errors was to change the support tools. As clinicians entered the patient medication list into the computer, there was no automated way to check for spelling, and the system also placed no limits on available drug strengths and routes. We also had difficulty with discharge medication reconciliation when there were multiple physicians only reconciling the medications they had ordered. Nurses or pharmacists were responsible for compiling relevant information for the physician to manually address. This resulted in a very complicated, complex and time consuming process. In addition, the instructions provided to patients upon discharge were not always clearly marked with changes that had been made.

We evaluated a variety of software programs with the intention to have software that fully supported the best clinical practice. The new tool contains a codified drug database, complete with strengths and indications that nurses will use to document the home medications. As the physician reviews medications and reconciles the desired scripts between home and hospital, there is now a user friendly, paperless process to make visible the exact action needed for each medication. Once the nurses input the home medication list, medications ordered during the patient stay are automatically added to the patient medication list, creating a living list of the patients' medication history that continues throughout the patient's stay. This saves time in medication reconciliation at discharge and ensures that each medication is addressed. This new software includes the ability for multiple physicians to reconcile medication on the same patient and has the ability for e-prescription, as well as fax notification to other physician providers.

The outcome for the patient is a list of medications that is easy for them to understand and clearly states which home medications are to continue, all changes to home medications, discontinued home medications and all new medication orders at discharge. We expect the improved accuracy and clarity will increase patient satisfaction, as well as improve the experience of our patients upon discharge. Additionally, the automation of this process will provide data for continued improvement. The software is also a huge physician satisfier as it is accessible from other sites, including the office where the patient's outpatient chart is located.

Alegent Health is very excited to provide our staff with a tool that streamlines their workflow and provides clear documentation to our patients. We are scheduled to go live in November 2009 at Alegent - Midlands and will roll out to other Alegent facilities shortly thereafter.



Spotlight on Creighton University Medical Center

By Dianne Hayko, RN, MS ~ Clinical Information System Coordinator & Informatics Specialist

English Camero, RN, MSN ~ Director of Intermediate Care

Identifying Ways to Improve Patient Outcomes

Creighton University Medical Center (CUMC) has implemented a CareTrek team consisting of the Director of Clinical Quality Improvement, Supervisor of Case Management/Social Work, Lead Social Work, Director of Intermediate Care and Clinical Information System Coordinator. The goal of this team is to identify ways we can improve the care transition process for our patients.

Assessed work patterns and workflow, then compared these processes to best practices in care transitions. Based on this assessment, it was determined the Project RED (Re-Engineered Discharge) Transition Model would be the best choice for our patients and our organization. Each phase of the Project RED model is aimed at improving patient safety by recreating the process by which patients leave the hospital.

Initial meetings have been scheduled with physician groups, home healthcare, skilled care facilities and community resource groups. For the initial rollout, the CUMC CareTrek team has determined the population best served would be patients with a heart failure diagnosis.

The telemetry step-down unit was chosen to pilot:

- ⦿ a more comprehensive online discharge instruction with follow-up appointments made for the patient;
- ⦿ a Clinical Nurse Leader to facilitate a smooth transition to the next level of care and;
- ⦿ a new process to provide timely communication related to discharge instruction and medication reconciliation to the PCP and physicians providing follow-up care within 24 to 48 hours post-discharge.

The next steps for CUMC's CareTrek team include evaluation of the discharge pilot, developing a roll-out plan for additional clinical areas, implementation of follow-up phone calls to discharged patients and continuation of process improvement initiatives with our community partners.

Components of Project RED

The Project RED intervention is founded on 11 discrete, mutually reinforcing components. A specially trained nurse called a Discharge Advocate introduces the intervention to the RED participant. Project RED components include:

1. Educate the patient about his or her diagnosis throughout the hospital stay
2. Make appointments for clinician follow-up and post-discharge testing
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up on the results
4. Organize post-discharge services
5. Confirm the Medication Plan
6. Reconcile the discharge plan with national guidelines and critical pathways
7. Review the appropriate steps for what to do if a problem arises
8. Expedite transmission of the Discharge Resume (summary) to the physician(s) (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge
9. Assess the degree of understanding by asking the patient to explain in their own words the details of the plan
10. Give the patient a written discharge plan at the time of discharge
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge

For more information, visit <http://www.bu.edu/fammed/projectred>.

Internet Patient Education Resources Available

by Marty Magee, National Network/Libraries of Medicine Education and Nebraska Liaison

Patient education is extremely important to help patients and family members understand the diagnoses, treatment and follow-up care for their condition. According to a recent Pew Internet study, eight in ten internet users have looked online for health information. As a healthcare professional, it is important that you are aware of free, accessible and credible resources that you can utilize with your patients to improve their healthcare experience.

The National Library of Medicine, as part of the National Institute of Health, offers a wealth of Web-based resources for patients, families and healthcare professionals. Primary among these is www.MedlinePlus.gov, a free consumer health Web site with accurate, easy-to-understand information on hundreds of health topics, drugs and supplements, medical news and much more. In addition, the interactive tutorials include more than 170 simple slideshow explanations with visual and audio commentary of conditions and procedures. Click on the "About MedlinePlus" link to locate the Medical Words tutorial, brochures to print for patients and professionals and MedlinePlus magazine subscription information.

For free information about the 'prescription' program for reliable health information, visit www.InformationRX.org. This site offers ways to order free materials, including MedlinePlus prescription pads, bookmarks, posters and much more.

Resources provided by the National Library of Medicine can be extremely helpful as you guide the patient through the care transition process. It is our role, as healthcare professionals, to ensure the patient has the resources and tools needed to be successful in understanding medications, diagnoses and treatments.

For additional information on these resources or others from the National Library of Medicine, contact your National Network of Libraries of Medicine liaison at 800-338-7657 or visit <http://nnlm.gov>.

Additional Resources

- ▣ U.S. Food and Drug Administration - Medicines in my Home
<http://www.fda.gov/medsinmyhome/>
- ▣ Chart for tracking your medications, dosage and prescribing physician at
<http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM095018.pdf>
- ▣ Personal Information Sheet and suggested questions for medicines or dietary supplements at
<http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM095018.pdf#page=2>

CTI™ Training in Omaha

A select number of volunteers and healthcare professionals from diverse organizations in Omaha had the opportunity to participate in the Care Transitions Intervention (CTI) training in mid-September. The CTI was developed and researched by Dr. Eric Coleman and his team at the University of Colorado. Dr. Coleman and two members of his team provided the CTI training for 27 participants interested in learning more about the CTI and the Transition Coach™.

The Transition Coach works with a patient for about 30 days post hospitalization to understand the four pillars (or concepts) of the CTI. The four pillars include: medication self-management, a personal health record (PHR), physician follow-up and knowledge of 'red flags'.

The Transition Coach is not a 'doer', but rather facilitates patient self-management of the four pillars. The patient becomes empowered to become better at self management of medications, is knowledgeable about signs that their condition is worsening, understands how and when to call the physician or pharmacist and has a personal health record for healthcare information and questions for the next physician visit.

With the assistance of a Transition Coach, patients become better at self-managing their own healthcare and are more likely to avoid unnecessary hospitalizations.

For additional information about the CTI and Transition Coach , visit <http://www.caretransitions.org>.

Care Transitions InterventionSM Model and Transition CoachTM; Eric A. Coleman, MD, MPH