2012 Quality Excellence Achievement Awards Compendium

Recognizing Illinois Hospitals and Health Systems Leading in Quality and Transformative Health Care
The Illinois Hospital Association’s (IHA) Institute for Innovations in Care and Quality (The Institute) second annual Quality Excellence Achievement Awards recognizes and celebrates the achievements of Illinois hospitals that are committed to transforming Illinois health care through innovative approaches and best practices.

From 67 submissions representing 40 hospitals, awards were presented to a total of eight hospitals in two categories: urban and rural/critical access. The two award recipients and six finalists, who were honored at IHA’s annual Leadership Summit, were selected by a panel of 30 nationally-recognized quality improvement leaders based on their achievement and progress in advancing one or more elements of the Institute of Medicine’s six aims for improvement:

- Safety
- Effectiveness
- Timeliness
- Efficiency
- Equity
- Patient-centered care

To share these initiatives among members, The Institute has published this compendium that provides a synopsis of all award entries along with contact information for additional details. The compendium receives national exposure by being featured annually on the Hospitals in Pursuit of Excellence (HPOE), an AHA affiliate, website.
Call for Entries
May 2013

Be sure to watch for this opportunity to be recognized and celebrated for your hospital’s achievements in advancing patient care.
Award Recipients
AWARD RECIPIENTS

Award category—Rural/Critical Access

Katherine Shaw Bethea Hospital, Dixon

*Streamlining the Intake Process of Cardiac Patients in the Emergency Department*

Award category—Urban

OSF Healthcare System, Peoria

*Improving Obstetrical Care Through Organizational Collaboration*

The following pages contain summaries of the award recipients’ projects.
Hospital/System: Katherine Shaw Bethea Hospital, Dixon

Contact: Dave Schreiner, FACHE
         President and CEO
         815-285-5501
dschreiner@ksbhospital.com

Project Title: Streamlining the Intake Process of Cardiac Patients in the Emergency Department

Summary: The goal was to improve turnaround times of troponin and EKGs within the cardiac patient population in the Emergency Department. The Chief Nursing Officer led this initiative, utilizing LEAN methodology with an interdisciplinary approach, focusing on streamlining patient flow. Strategies for improvement included revising the care delivery model during high volume times and shifting to a nurse initiated triage protocol, including STAT EKGs and STAT Labs.

The outcome was a 62% improvement in door-to-troponin results within 60 minutes, and a 32% improvement in door-to-EKG within 10 minutes. As a result, length of stay for cardiac patients decreased by 11 minutes and patients who left without being treated decreased to 1.59%.

Website: https://www.ksbhospital.com
Infants born to mothers electively at a gestational age of 37-39 weeks are more likely to develop respiratory distress requiring mechanical ventilation. These children are more likely to have lifelong problems with asthma and other respiratory ailments. In central Illinois, there has been an increase in neonates requiring ventilator support as a result of elective deliveries.

A regional collaborative was created to improve the process and outcomes of obstetrical care. Using a systems approach, the rate of non-medically indicated inductions and C-sections decreased from 18% to 3.8%. The rate of infants requiring respiratory support did not change and the number of stillbirths did not increase despite a longer gestational age.

Website:  
http://www.osfhealthcare.org
Award Finalists
AWARD FINALISTS

Rural/Critical Access category

**Gibson Area Hospital & Health Services, Gibson City**
Reduce Medication Errors Through the Implementation of Computerized Physician Order Entry (CPOE), Medication Bar Coding and Smart Pump Technology

**Graham Health System, Canton**
Intensive Care Management

**St. Mary’s Hospital, Centralia**
Reducing Readmissions CQI+ Team—Implementing Change Through the IHA Project RED Collaborative

Urban category

**Advocate Hope Children’s Hospital, Oak Lawn**
Utilization of an Interdisciplinary Team Approach for the Care of Infants with Hypoplastic Left Heart Syndrome (HLHS)—The Ideal Quality Improvement Collaboration

**Alexian Brothers Health System, Arlington Heights**
Improvement in Patient Safety and Quality of Inpatient Care Through Appropriate Blood Product Management

**Holy Family Medical Center, Des Plaines**
Collaborative Approach to Reduce Health Care-Acquired Clostridium difficile Infection Rate in a Long-Term Acute Care Hospital (LTACH)

The following pages contain summaries of the award finalists’ projects.
AWARD FINALIST – Rural/Critical Access category
Medication Administration

Hospital/System: Gibson Area Hospital & Health Services, Gibson City

Contact: Sylvia Day
QI/Risk Management
217-784-2607
Sylvia_day@gibsonhospital.org

Project Title: Reduce Medication Errors Through the Implementation of Computerized Physician Order Entry (CPOE), Medication Bar Coding and Smart Pump Technology

Summary: After acknowledging that medication errors were on the rise, the facility implemented computerized physician order entry (CPOE) and medication barcoding to assist with medication verification, and initiated the transition to smart pump technology that included safety software.

Drug libraries were developed within clinical areas which included hard and soft stops to help prevent medication dosing errors.

With these new implementations, the facility has seen a 30% reduction in medication errors for 2011-2012.

Website: http://www.gibsonhospital.org
Project Title: Intensive Care Management

Summary: The project catalyst noted inconsistencies in providing diagnosis-related, evidence-based interventions to all applicable patients. This resulted in varied patient care, patient outcomes and data consistency.

In July 2011, the Intensive Care Management team began the process to resolve the identified issues and established an Intensive Care Manager position to complement Case Management. This person is part of an interdisciplinary team. The Case Manager ensures evidence-based protocols are followed, and that communication with the physician occurs when interventions are not completed/ordered for the patient.

Core measure interventions have improved with corresponding improvement in nine of nine value-based purchasing indicators (three are not applicable) ranging from 1% - 19% from baseline. Length of stay has improved from 3.51 in June 2011 to 3.34 in May 2012. The project is now stepping into the next phase of intensive outpatient management of chronic disease.

Website: http://www.grahamhospital.org
Project Title: Reducing Readmissions CQI+ Team—Implementing Change Through the IHA Project RED Collaborative

Summary: The all-cause 30-day readmission rates for the hospital are higher than both the state and national average for all three quality indicators (AMI, CHF and community-acquired pneumonia). In January 2011, the hospital started a new CQI+ team to implement the Illinois Hospital Association (IHA) Project Re-Engineering Discharge (RED) Collaborative.

Working through the CQI process steps, sub-teams created process maps for each of the six target areas: medication reconciliation, patient/family education, internal and external communication, after-discharge follow-up, discharge instructions, and RED implementation.

Patient follow-up included a minimum of five phone calls during the 30-day post-discharge period. Health coaches generally make one home visit and often attend physician appointments with the patient in order to create seamless care coordination and ensure that the discharge plan of care is carried out. As a result, readmission rates in all categories are trending downward.

Website: http://www.smgsi.com
Utilization of an Interdisciplinary Team Approach for the Care of Infants with Hypoplastic Left Heart Syndrome (HLHS)—The Ideal Quality Improvement Collaboration

Summary: Development of a Norwood Clinic allowed the quality improvement team to create goals to decrease morbidity and mortality and improve the long-term quality of life for patients with HLHS.

Over the past year, the hospital focused on innovative operative and post-operative care, effective care transitions, achieving adequate growth, parent engagement, discharge care coordination, and proactive rehabilitation assessment and intervention.

Length of stay (LOS) decreased from 31.1 to 16.5 days. Readmission rates dropped from 1.21 to 0.79 admissions/patient. Also, there has been a decline in LOS for all congenital heart surgery patients—dropping from 22.9 days (2009) to 6.94 days (2012).

Website: [http://www.advocatehealth.com/hope](http://www.advocatehealth.com/hope)
<table>
<thead>
<tr>
<th>Hospital/System:</th>
<th>Alexian Brothers Health System, Arlington Heights</th>
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| Contact:        | Diana Woytko  
Vice President Patient Safety and Quality, ABHS  
847-385-7151  
Diana.Woytko@alexian.net |
| Project Title:  | Improvement in Patient Safety and Quality of Inpatient Care Through Appropriate Blood Product Management |
| Summary:        | The hospital carried out a multidisciplinary team-based approach to improving the safety and appropriateness of packed red blood cells (PRBC) transfusion. Evidence-based guidelines for appropriate usage of blood products and a standardized order set were developed. Compliance with the guidelines was monitored, and lessons were incorporated to effect rapid cycle change. 

The program resulted in a 33.6% decrease in PRBC transfused per 1,000 patient days over a 10-month period while PRBC transfused for hemoglobin levels above 7 g/dl decreased from 73.6% to 49.6%.

A decrease in multiple unit transfusions was achieved by encouraging practitioners to transfuse one unit of PRBC in stable patients followed by clinical reassessment of the need for further transfusion. |
| Website:        | http://www.alexianbrothershealth.org |
Hospital/System: Holy Family Medical Center, Des Plaines

Contact: Kathy Hollich
Performance Improvement Coordinator
847-813-3514
khollich@reshealthcare.org

Project Title: Collaborative Approach to Reduce Health Care-Acquired Clostridium difficile Infection Rate in a Long-Term Acute Care Hospital (LTACH)

Summary: The medical center’s mission was to reduce the C. difficile rate from 26.7 cases per 10,000 patient days to a rate below 12.1. A multidisciplinary team was formed that utilized the PDSA cycle to evaluate and implement a plan of action.

Improvement interventions began with the team evaluating and then developing and revising the room cleaning procedures. Employees were re-trained in the correct use of the required PPE and proper hand hygiene. A physician champion informed the medical staff of the team’s progress and emphasized their role in reducing C. diff infections. Families and visitors were involved in the “Help Stop the Spread of Infection Program.”

FY2012 continues to show a decreasing trend with a rate of 7.4 cases per 10,000 patient days.

Website: http://holyfamilymedicalcenter.reshealth.org/sub_hfmc
Applicants

Infection Prevention
Infection Prevention

Hospital/System: Advocate Hope Children’s Hospital, Oak Lawn

Contact: Colleen A. Perez, RN, MS, NEA-BC
Director, Quality and Regulatory Compliance
708-684-5067
collen.perez@advocatehealth.com

Project Title: Eliminating Catheter-Associated Bloodstream Infections (CLABSI) System-Wide: Expanding Quality Improvement Practices Beyond Critical Care Units

Summary: This quality project evaluated the impact of translating evidence-based CLABSI practice from the adult population to the pediatric population to eliminate pediatric CLABSI.

The hospital joined a national collaborative in December 2009 that focused on developing and sustaining a program that eliminates pediatric CLABSI while engaging key physicians, infectious disease practitioners and nurses specifically dedicated to quality improvement measures.

After joining the collaborative, PICU improved their CLABSI rates to 1.65 per 1,000 catheter days in 2011 and is currently at a rate of 1.1 per 1,000 catheter days for 2012—over 140 days bloodstream infection (BSI) free. PSHU improved their rates to 2.94 per 1,000 catheter days in 2011 and is currently 0.0 per 1,000 catheter days in 2012 and over 300 days BSI free.

Website: http://www.advocatehealth.com/hope
Hospital/System: Carle Foundation Hospital, Urbana

Contact: Napoleon Knight, MD
Medical Director Hospital Medicine/Associate Medical Director of Quality
217-383-5384
Napoleon.Knight@Carle.com

Project Title: On the CUSP: Stop BSI, an IHA Offered Collaborative to Reduce Central Line-Associated Bloodstream Infections (CLABSI)

Summary: The hospital joined the On the CUSP: Stop BSI (bloodstream infection) collaborative offered by IHA. The focus was on CLABSI reductions starting in the Surgical Intensive Care Unit (SICU), and then house-wide, including the Cardiovascular Intensive Care Unit (CVICU), using the same evidence-based best practices.

Building on their 2007 CLABSI-reduction collaborative, CUSP allowed them to evaluate needed improvements to achieve their reduction goals and to work toward sustained reductions.

CVICU CLABSI data show an 80% reduction in cases from 2010 (5 cases) to 2011 (1 case). Zero cases were identified in the 2012 data available to date (January–May).

Website: http://www.carle.org
Infection Prevention

Hospital/System: Memorial Hospital, Belleville
Contact: Kerry Wrigley
Director Quality Improvement
618-257-5328
kwrigley@memhosp.com

Project Title: Ventilator-Associated Pneumonia (VAP): Reduction, Accountability and Commitment

Summary: An opportunity was identified to improve the care of the ventilated patient through education and adoption of the Institute for Healthcare Improvement’s Evidence-Based Care Bundle for the mechanically ventilated patient. A Six Sigma statistical process control chart analysis for VAPs identified a special cause variation in June 2011 that signaled a change in a process and was cause for immediate investigation.

Sources of variation were brainstormed and several issues were immediately identified. Quick fixes implemented included changes in oral care and ventilator products used, implementation of rotational therapy, daily rounding improved nursing documentation compliance of VAP bundle practice, physical changes to ICU rooms, and changes in housekeeping and environmental cleaning protocol.

With a renewed culture of accountability and commitment in the VAP prevention, there have been zero VAP incidents in seven months (November 1, 2011–May 31, 2012). Overall compliance with nursing documentation of five key ventilator bundle elements was 59% and improved to 90% by fourth quarter 2011.

Website: http://www.memhosp.com
Project Title: Managing Clostridium Difficile Using a Bundled Approach

Summary: In October 2010, Memorial Medical Center implemented an intervention “bundle” designed to reduce onset of C. diff by 15% from prior year baseline. The bundle included five elements: (1) contact precautions, (2) hand washing, (3) environmental cleaning, (4) laboratory alerts, and (5) staff education.

For 12 months (ending September 2011), incidence of C. diff decreased by 31% over prior year; in fact, zero cases occurred for six consecutive months, supporting the utility of the five-element treatment bundle.
Hospital/System: MetroSouth Medical Center, Blue Island

Contact: Gayle Toscano  
Director of Performance Improvement  
708-824-4518  
Gayle_Toscano@metrosouthmedicalcenter.com

Project Title: *Elimination of Central Line-Associated Blood Stream Infections through Best Practices in an Urban Acute Care Hospital*

Summary: Following a high rate of central line-associated blood stream infections (CLABSI) in the fourth quarter of 2008, a performance improvement project was initiated with the goal of eliminating all CLABSI while providing safe, effective, efficient, and patient-centered care to patients with central lines. A coordinated interdisciplinary plan was put in place and strict adherence to central line insertion site planning and procedural protocols was enforced.

Observing hand hygiene, maximal barrier precautions, Chlorhexidine skin antisepsis, optimal catheter site selection (subclavian vein preferred), daily review of line necessity, and assignment of daily rounding and site care and dressing changes to the IV Therapy Team for care continuity have resulted in a zero CLABSI rate since the second quarter of 2009.

Website: [http://www.metrosouthmedicalcenter.com](http://www.metrosouthmedicalcenter.com)
Infection Prevention

Hospital/System: Pekin Hospital, Pekin

Contact: Beth Thomas, RN, BSN, CPHQ, CPHRM, MSHA
Director Patient Safety and Quality Initiatives
309-353-0340
bthomas@pekinhospital.com

Project Title: Reducing the Pains of Change—Total Knee Replacement Postoperative Infection Prevention

Summary: Utilizing PDSA, the hospital’s multidisciplinary team utilized evidence-based best practices to enhance the patient care experience associated with total knee replacement surgery through improved patient education and improved surgical outcomes, including a reduction in the risk of postoperative infections.

Innovations included developing a surgical bath protocol and patient education packet, and a pre-op total joint class, curriculum and guidebook, including the creation of total knee replacement surgery information booklet.

Since 2007, these innovative strategies have led to the current KPRO rate of 0.76 infections per 100 procedures and the Joint Commission National Quality Core Measures scores of 100% for prophylactic antibiotic within one hour of surgery and 96.6% for antibiotic discontinuation within 24 hours of surgery. Additionally, the innovations have led to a reduction in the per capita cost of care for total knee replacement surgery postoperative infections.

Website: http://www.pekinhospital.org
Infection Prevention

Hospital/System: Resurrection Medical Center, Chicago

Contact: Heather Murphy
Director, Performance Distinction
773-774-8000 ext. 6210
HMurphy@reshealthcare.org

Project Title: UV-Light Disinfectant Study

Summary: A hospital study was conducted to evaluate the practicality and effectiveness of UV-light as a germicidal disinfectant after the Environmental Service (EVS) terminally cleaned confirmed C. diff patient rooms at discharge.

Various swab collections of room surface areas took place during a control phase, baseline testing phase and testing phase, to prove or disprove the use of UV-light adjunct to EVS cleaning.

Results showed that tested rooms had experienced a meaningful colony count reduction when using UV-light in C. diff rooms. However, procedures must be clearly defined, as well as the workflow process, to avoid impeding bed availability and turn-around time. Additional EVS cleaning process improvements were made to complement the UV-light disinfectant.

Website: http://www.reshealth.org
Project Title: Nurse-Driven Protocol for Urinary Catheter Removal

Summary: A nurse-driven protocol was implemented to increase the staff’s awareness on the appropriate indications of an indwelling urinary catheter to reduce the use of indwelling urinary catheters and catheter-associated urinary tract infections (CAUTI).

After receiving education, nursing staff was charged with completing the review of need forms daily for each patient with a urinary catheter. According to the protocol, if the patient does not meet the requirement for a urinary catheter, it is discontinued without a physician order.

Although the hospital did not decrease the prevalence rate for urinary catheter days, the use of urinary catheters was appropriate and the rate of CAUTI had decreased.
**Project Title:** Reaching Zero Central Line-Associated Infections by Improving Compliance to Aseptic Technique

**Summary:** Central line-associated bloodstream infections continued to occur in the adult Intensive Care Unit despite the implementation of the Institute for Healthcare Improvement’s Central Line Bundle. Compliance with central line bundle was high, yet observations revealed breaks in aseptic technique during skin preparation, line insertion and port access.

Collaboration between infection prevention and IV therapy revealed that the kits used for dressing changes and port access needed to be configured to support compliance with aseptic technique. After staff education, collaboration with the dressing change kit vendor and staff commitment to patient safety, the rate for the adult medical/surgical Intensive Care Unit has remained at zero for 17-consecutive months.
Infection Prevention

Hospital/System: St. Elizabeth’s Hospital, Belleville

Contact: Kimberly Mitchell
Manager Performance Excellence
618-234-2120 ext. 1152
kmitchell@sebh.org

Project Title: Surviving Sepsis Campaign

Summary: The purpose of the project was to improve the recognition and early goal directed treatment of patients with sepsis to reduce mortality rates by 50% in one year from implementation. The hospital used multi-point strategies provided by the Surviving Sepsis Campaign (SSC) to help guide practitioners in the recognition and treatment of these critically ill patients providing an opportunity for a positive outcome.

Since implementation, overall compliance with the four elements of the sepsis resuscitation order set increased from 34.6% to 90.7%. The mortality rate decreased to an overall 16% since implementation from a baseline of 42%.

Website: http://www.steliz.org
Infection Prevention

Hospital/System: St. Mary’s Good Samaritan Inc. (Good Samaritan Regional Health Center, Mount Vernon and St. Mary’s Hospital, Centralia)

Contact: Michelle Darnell
Vice President Systems Improvement
618-241-2218
Michelle_Darnell@ssmhc.com

Project Title: Reducing Hospital-Acquired Clostridium Difficile (C. diff)

Summary: Harm/hospital-acquired condition reports were sent to each hospital. In reviewing both campuses, each was in the "red" on the scorecard for hospital-acquired C. diff. A CQI+ team was sanctioned to reduce hospital-acquired C. diff by half from a high of 11 cases per month to 5.5 cases per month.

The C. diff CQI+ team utilized innovation, sharing of best practices and Lean/Six Sigma process improvement strategies to focus on decreasing hospital-acquired C. diff. The team was able to change the organization’s culture and reduce the number of hospital-acquired C. diff by more than half, and realized a five-fold decrease in hospital-associated C. diff cases.

Website: http://www.smgsi.com
Infection Prevention

Hospital/System: Sherman Hospital, Elgin

Contact: Ushma Lakhani
Manager, Clinical Excellence
224-783-8686
Ushma.lakhani@shermanhospital.org

Project Title: Finding the Needle in the Haystack: Critical Care’s Journey to Zero VAPs

Summary: The Critical Care Unit identified Ventilator-Associated Pneumonia (VAP) as an area for improvement, with three VAPs from May-July 2011, and five from May-October 2011.

The hospital identified best practices, developed engaged staff and physician champions, achieved multidisciplinary collaboration, and identified opportunities to celebrate.

As of May 2012, they improved their clinical outcomes related to Ventilator-Associated Pneumonia, and have been without a VAP in Critical Care for seven months.

Website: http://www.shermanhealth.com
Infection Prevention

Hospital/System: Sherman Hospital, Elgin

Contact: Ushma Lakhani
Manager, Clinical Excellence
224-783-8686
Ushma.lakhani@shermanhospital.org

Project Title: *Foleys Aren’t Fun: A Hospital Leadership Team’s Journey to Reducing Catheter-Associated Urinary Tract Infections (CAUTIs)*

Summary: After identification of an opportunity to reduce CAUTIs, leadership headed an initiative to reduce the incidence of infection and foley utilization. A drive for improvement was managed by nursing leadership by instituting safety huddles, completing daily review of foley utilization, and implementing standard of care guidelines for foley indication.

The awareness, discussion and culture change, allowed the hospital to reduce their CAUTI rate from 2.0 (3rd quarter 2011) to .29 (1st quarter 2012) and decreased percent unnecessary urinary catheters from 24.7% (3rd quarter 2011) to 9.5% (2nd quarter 2012).

Website: [http://www.shermanhealth.com](http://www.shermanhealth.com)
Infection Prevention

Hospital/System: Trinity Regional Health System, Rock Island

Contact: Andrew Behan
Manager, Infection Prevention
309-779-2797
behanaz@ihs.org

Project Title: The Red Box Strategy: An Innovative Method to Improve Isolation Precaution Compliance and Reduce Costs

Summary: The Red Box Strategy was created to help reduce cost and health care worker time associated with having to unnecessarily don and doff personal protective equipment (PPE) while still providing quality care.

Using evidence-based practices, the hospital’s infection prevention team implemented a three-foot square “safe zone” using red duct tape in the doorways of patients in contact isolation rooms to serve as a visual cue from which health care workers can communicate with patients without having to put on PPE.

During a two-year analysis of the Red Box Strategy, Trinity saved up to 2,700 staffing hours (time previously spent unnecessarily donning PPE) and significantly reduced personal protective equipment costs annually. It allowed staff to respond faster to patient requests, lessened communication barriers and increased patient and staff satisfaction.

Website: http://www.trinityqc.com
Applicants

Medication Administration
Medication Administration

Hospital/System: Advocate Hope Children’s Hospital, Oak Lawn

Contact: Colleen A. Perez, RN, MS, NEA-BC
Director, Quality and Regulatory Compliance
708-684-5067
collen.perez@advocatehealth.com

Project Title: *Antibiotic Administration in One Hour or Less for Pediatric Oncology Patients with Fever and Neutropenia*

Summary: To reduce the time to first dose of antibiotics to directly admitted pediatric oncology patients with febrile neutropenia, an interdisciplinary quality improvement team systematically analyzed admission and treatment processes to identify barriers to care and key tactics for process improvement.

A 67% reduction in time to first dose of antibiotics was achieved; the rate of patients receiving their first dose of antibiotics within one hour increased from 24% to 93%.

Website: [http://www.advocatehealth.com/hope](http://www.advocatehealth.com/hope)
AWARD FINALIST – Rural/Critical Access category
Medication Administration

Hospital/System: Gibson Area Hospital & Health Services, Gibson City

Contact: Sylvia Day
QI/Risk Management
217-784-2607
Sylvia_day@gibsonhospital.org

Project Title: Reduce Medication Errors Through the Implementation of Computerized Physician Order Entry (CPOE), Medication Bar Coding and Smart Pump Technology

Summary: After acknowledging that medication errors were on the rise, the facility implemented computerized physician order entry (CPOE) and medication barcoding to assist with medication verification, and initiated the transition to smart pump technology that included safety software.

Drug libraries were developed within clinical areas which included hard and soft stops to help prevent medication dosing errors.

With these new implementations, the facility has seen a 30% reduction in medication errors for 2011-2012.

Website: http://www.gibsonhospital.org
Hospital/System: Holy Family Medical Center, Des Plaines

Contact: Kathy Hollich  
Performance Improvement Coordinator  
847-813-3514  
khollich@reshealthcare.org

Project Title: Collaborative Approach to Reduce Health Care-Acquired Clostridium difficile Infection Rate in a Long-Term Acute Care Hospital (LTACH)

Summary: The medical center’s mission was to reduce the C. difficile rate from 26.7 cases per 10,000 patient days to a rate below 12.1. A multidisciplinary team was formed that utilized the PDSA cycle to evaluate and implement a plan of action.

Improvement interventions began with the team evaluating and then developing and revising the room cleaning procedures. Employees were re-trained in the correct use of the required PPE and proper hand hygiene. A physician champion informed the medical staff of the team’s progress and emphasized their role in reducing C. diff infections. Families and visitors were involved in the “Help Stop the Spread of Infection Program.”

FY2012 continues to show a decreasing trend with a rate of 7.4 cases per 10,000 patient days.

Website: http://holyfamilymedicalcenter.reshealth.org/sub_hfmc
Hospital/System: Norwegian American Hospital, Chicago

Contact: Karen Kraker, RN
Director of Quality
773-292-8219
KKraker@nahospital.org

Project Title: One Step at a Time: Addressing Hypoglycemia Adverse Drug Events by Improving Insulin Management Through Rapid Cycle Improvement and Spread Process

Summary: After several monthly reviews of reported adverse drug events, hypoglycemia ranked highest for the hospital. Upon further review, the majority of hypoglycemic events were associated with the use of insulin, a high-alert medication. In fall 2011, a multidisciplinary team was created to develop a standardized diabetes order set and hypoglycemia treatment protocol, and update an outdated diabetes flow sheet.

Despite the time and resources dedicated to these efforts, there was little to no adoption of new standardized processes. Hypoglycemic events remained unchanged. The hospital then de-escalated their approach to a unit specific pilot with continuous Plan-Do-Study-Act (PDSA) cycles and education on the floors by decentralized clinical staff pharmacists, nurse educators and clinical dietitians.

Three months later, hypoglycemic events have decreased by 34%.

Website: http://www.nahospital.org
Hospital/System: St. John’s Hospital, Springfield

Contact: Diane Tebrugge
Quality Director
217-544-6464 ext. 45382
diane.tebrugge@st-johns.org

Project Title: “Patient-Centered Value through Pharmacy-Led Interventions”–Goal is to Achieve 100% Compliance with Antibiotic Selection and Timing, and Sustain Performance

Summary: In late January 2012, pharmacists began reviewing potential pneumonia patients using a screening tool developed by the quality management team. A list of patients with diagnosis codes that had previously been identified as possible pneumonia patients prints twice daily. Pharmacists review each patient on this list for CMS inclusion criteria based on their admitting diagnosis, physician history and physical, emergency department records, and progress notes.

If the patient is determined as a possible community-acquired pneumonia patient, the antibiotics are reviewed for appropriateness. When a patient has been identified as not being on the appropriate antibiotics, the physician is called and requested to change therapy.

Since implementing this process, the hospital has achieved 100% compliance on antibiotic selection and timing for pneumonia patients.

Website: https://www.st-johns.org
### Medication Administration

**Hospital/System:** Silver Cross Hospital, New Lenox  

**Contact:**  
David Schlappy  
Vice President Quality and Medical Staff Services  
815-300-7102  
dschlappy@silvercross.org

**Project Title:**  
*Improving Patient Safety Through Timely and Accurate Medication Reconciliation*

**Summary:**  
The Heart Failure Quality Improvement Team set out to improve scores on heart failure Core Measures. In fiscal year 2010, the hospital’s failure rate was 42%, with a high of 63% in November 2010. This project focused on improving the health of hospitalized patients by increasing medication safety.

The team’s work led to an overall rate reduction of errors related to medication reconciliation in hospitalized patients of 13% in March 2012.

**Website:**  
http://www.silvercross.org
Applicants

Patient Experience
Patient Experience

Hospital/System: Franciscan St. James Health, Chicago Heights

Contact: Bill Dwyer
Director of Quality Improvement
708-747-4000 ext. 1070
William.dwyer@franciscanalliance.org

Project Title: Creating the Ideal Outpatient Experience

Summary: The driving principle behind the Outpatient Service Excellence Journey is excellent customer service with every interaction.

This began with the Outpatient Team, including representatives from all outpatient areas, meeting biweekly to focus on the ideal patient experience. The goal was to engage every member of the workforce while encouraging departments to take ownership for the patient experience and giving them the tools to make it happen.

The initiatives have resulted in steady, significant patient satisfaction improvement. Overall rank improved from the 9th percentile in 1st quarter of 2008 to the 82nd percentile in 1st quarter of 2012. The improvements are also evidenced in their increased outpatient volume, better financial outlook and positive word-of-mouth in the community.

Website: http://www.franciscanalliance.org/hospitals/chicagoheights/Pages/default.aspx
Patient Experience

Hospital/System: Rush-Copley Medical Center, Aurora

Contact: Diane D. Homan, MD
Vice President, Quality & Patient Safety Officer
630-978-6208
Diane.Homan@rushcopley.com

Project Title: *Health Literacy: Initiative to Advance Patient-Centered Care*

Summary: A team was created to ensure that all patients regardless of race, ethnicity, language, disability, and sexual orientation received the same level of care.

A gap analysis identified additional translation resources were needed for sign language as well as infrequently used languages; race and ethnicity data needed to be collected using a more reliable method; documentation of preferred language for health care was needed to help staff tailor patient care; and communication to patients regarding resources available was lacking.

After implementing changes, interpretation usage hours increased 73% from baseline period with a gradual increase over a 12-month period. Preferred language for health care needs was documented in the medical record and compliance has gradually improved from 84% to present rate of 99% over a 10-month period, and sustained for most recent six months at 99%.

Website: [http://www.rushcopley.com](http://www.rushcopley.com)
Applicants

Process Improvement—Clinical
Process Improvement—Clinical

Hospital/System: Adventist Bolingbrook Hospital, Bolingbrook

Contact: Jamie Rowden
Director of Quality
630-312-6056
Jamie.rowden@ahss.org

Project Title: Glycemic Collaborative—A Multidisciplinary Team Created to Assist with Glycemic Control in an Acute Hospital Setting

Summary: The glycemic collaborative is an ongoing, multidisciplinary initiative developed to improve blood glucose management for adult hyperglycemic patients during acute inpatient hospitalization. The goals are to develop improvement strategies that will manage blood glucoses to prevent hypoglycemia (blood glucose of 40mg/dL or less) and to prevent/reduce hyperglycemic events by assisting the hospital to maintain average glucose values between 70 and 180 mg/dL. The team met monthly to review data, discuss improvements and complete small tests of change.

Over two years, there has been a decrease of hypoglycemic events in the Intensive Care Unit, and an increase in the average glucoses between 70mg/dL and 180mg/dL in the Medical/Surgical and Intensive Care Units.

Website: http://www.keepingyouwell.com/abh
Process Improvement–Clinical

Hospital/System: Adventist Bolingbrook Hospital, Bolingbrook

Contact: Jamie Rowden
Director of Quality
630-312-6056
Jamie.rowden@ahss.org

Project Title: *Peripherally Inserted Central Catheter (PICC)-Associated Deep Vein Thrombus (DVT) Reduction*

Summary: The PICC team was created in March 2010 after the facility had documented an increase in PICC-associated DVTs. The team’s goal was to review how PICC lines were inserted and maintained. After comparing the process to evidence-based medicine, a number of steps were changed including the manner of insertion and daily maintenance. Educators worked with nurses on how to properly maintain PICC lines. The quality department tracked each PICC line inserted to ensure the PICC was properly placed, the correct orders were entered, arm circumference was measured daily, and proper maintenance—such as flushing—was completed.

As a result, the PICC line-associated DVT rate decreased from 14% at its highest month to 2-3% currently.

Website: [http://www.keepingyouwell.com/abh](http://www.keepingyouwell.com/abh)
Process Improvement–Clinical

Hospital/System: Adventist GlenOaks Hospital, Glendale Heights

Contact: Susan Ford
Quality and Patient Safety Clinical Specialist
630-545-7233
Susan.Ford@ahss.org

Project Title: Therapeutic Hypothermia: Improving Outcomes

Summary: In 2009, the leadership team of this hospital empowered its multidisciplinary Critical Care Committee to develop and implement a Therapeutic Hypothermia protocol. The protocol was instituted at the patient’s point-of-entry via the Emergency Department for all out-of-hospital, post-cardiac arrest patients. The goal was to improve neurological outcomes for unresponsive adult patients who had been successfully resuscitated after experiencing a cardiac arrest. Additional aims included: reducing the time required to achieve the cooling temperature goal and maintaining a safe, gradual passive re-warming phase.

Website: http://www.keepingyouwell.com/agh
Hospital/System: Adventist Hinsdale Hospital, Hinsdale

Contact: Steve Brown
Director, Operational Excellence
630-856-6027
steve.brown@ahss.org

Project Title: Transforming Patient Care Through Optimal Patient Placement

Summary: The hospital was experiencing higher costs and lower quality care than its competitors based on data from The Commonwealth Fund and MEDPAR.

After working with a consulting firm, it was determined that some patients were placed on inappropriate units for their required level of care. A seven-month project was launched to consolidate the areas, all while working to improve quality, patient, physician and employee satisfaction, and reduce costs. Care levels were consolidated from four levels to three—critical care, a step down or intermediate level, and med/surg. Patients would move twice instead of three times, when necessary, and would be admitted to the right level of care upon admission, whenever feasible, thus utilizing the most appropriate nursing staff.

Website: http://www.keepingyouwell.com/ahh
Process Improvement–Clinical

Hospital/System: Advocate Good Shepherd Hospital, Barrington

Contact: Marianne Araujo
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Marianne.Araujo@advocatehealth.com

Project Title: *Stroke Alert: Collaboration to Excellence*

Summary: The hospital developed a comprehensive, multidisciplinary stroke program to provide patients with rapid, appropriate and guideline-based treatments to help improve their chances of recovery.

In keeping the patient-centered care philosophy, the team collaborated, analyzed, developed, and implemented an organized approach to acute stroke care. The introduction of evidence-based stroke alert indicators was the catalyst for the education and knowledge assessment process. The development of role-specific tasks was a collaborative approach that instilled a sense of ownership and lead to a successful quality improvement project.

Website: [http://www.advocatehealth.com/gshp](http://www.advocatehealth.com/gshp)
Project Title: Utilization of an Interdisciplinary Team Approach for the Care of Infants with Hypoplastic Left Heart Syndrome (HLHS)—The Ideal Quality Improvement Collaboration

Summary: Development of a Norwood Clinic allowed the quality improvement team to create goals to decrease morbidity and mortality and improve the long-term quality of life for patients with HLHS.

Over the past year, the hospital focused on innovative operative and post-operative care, effective care transitions, achieving adequate growth, parent engagement, discharge care coordination, and proactive rehabilitation assessment and intervention.

Length of stay (LOS) decreased from 31.1 to 16.5 days. Readmission rates dropped from 1.21 to 0.79 admissions/patient. Also, there has been a decline in LOS for all congenital heart surgery patients—dropping from 22.9 days (2009) to 6.94 days (2012).

Website: http://www.advocatehealth.com/hope
Hospital/System: Advocate Hope Children’s Hospital, Oak Lawn

Contact: Colleen A. Perez, RN, MS, NEA-BC
Director, Quality and Regulatory Compliance
708-684-5067
Colleen.Perez@advocatehealth.com

Project Title: Walking the Walk: A Progressive Mobility Protocol in a Cardiovascular Surgical Intensive Care Unit Improves Patient Perception and Results in Lower Costs Through Decreased Ventilator Hours and Length of Stay (LOS)

Summary: Early and safe mobility of critically ill patients in a cardiovascular surgical intensive care unit (CVICU) was addressed in this study. Using a multilevel mobility protocol, the team aimed to decrease the CVICU LOS, decrease ventilator hours, and evaluate the patients’ experience of care related to mobility.

FOCUS-PDSA was used to develop a mobility protocol for use within the patients’ acute care environment. Their perception of mobility was measured in three phases using a visual analog scale.

The mobility protocol included bed and transfer activities, and ambulation. Patients reported a significant improvement in their perception of mobility during their CVICU LOS. The mean number of ventilator hours decreased from 63 hours to 35 hours. CVICU LOS decreased in three of four surgical categories; the largest decrease (10.8 CVICU days) experienced by ventricular-assist device patients.

The CVICU group experienced zero falls, an overall decrease in the pressure ulcer occurrence rate and no loss of lines, drains or endotracheal tubes during mobility.

Website: http://www.advocatehealth.com/hope
Hospital/System: Alexian Brothers Health System, Arlington Heights

Contact: Diana Woytko
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Diana.Woytko@alexian.net

Project Title: Improvement in Patient Safety and Quality of Inpatient Care Through Appropriate Blood Product Management

Summary: The hospital carried out a multidisciplinary team-based approach to improving the safety and appropriateness of packed red blood cells (PRBC) transfusion. Evidence-based guidelines for appropriate usage of blood products and a standardized order set were developed. Compliance with the guidelines was monitored, and lessons were incorporated to effect rapid cycle change.

The program resulted in a 33.6% decrease in PRBC transfused per 1,000 patient days over a 10-month period while PRBC transfused for hemoglobin levels above 7 g/dl decreased from 73.6% to 49.6%.

A decrease in multiple unit transfusions was achieved by encouraging practitioners to transfuse one unit of PRBC in stable patients followed by clinical reassessment of the need for further transfusion.

Website: http://www.alexianbrothershealth.org
Project Title: Intensive Care Management

Summary: The project catalyst noted inconsistencies in providing diagnosis-related, evidence-based interventions to all applicable patients. This resulted in varied patient care, patient outcomes and data consistency.

In July 2011, the Intensive Care Management team began the process to resolve the identified issues and established an Intensive Care Manager position to complement Case Management. This person is part of an interdisciplinary team. The Case Manager ensures evidence-based protocols are followed, and that communication with the physician occurs when interventions are not completed/ordered for the patient.

Core measure interventions have improved with corresponding improvement in nine of nine value-based purchasing indicators (three are not applicable) ranging from 1% - 19% from baseline. Length of stay has improved from 3.51 in June 2011 to 3.34 in May 2012. The project is now stepping into the next phase of intensive outpatient management of chronic disease.

Website: http://www.grahamhospital.org
Process Improvement–Clinical

Hospital/System: Jesse Brown Veterans Administration Medical Center, Chicago

Contact: Deborah Barker
Chief, Performance Improvement
312-569-6194
Deborah.Barker3@va.gov

Project Title: Improving Care for our Nation’s Veterans—Transradial Catheterization Training Research Program

Summary: In December 2009, the medical center embarked on a little known and practiced procedure in the United States: Transradial Catheterization. As growing scientific evidence about the safety and efficacy of this approach became more apparent, the medical center determined a course of action should be taken to provide the most up-to-date care for veterans in Chicago and at VA medical centers nationwide.

The Transradial Angiography Training Research Program, implemented in July 2012, trains VA hospitals that do not currently perform transradial procedures and converts them into a primary transradial program. A Radial Catheterization Team was developed at the Jesse Brown VAMC to address complications, success rates and patient satisfaction with radial catheterization.

Of the patients surveyed, 97% preferred the radial approach over the femoral approach. 94% of the patients would recommend the radial approach over the femoral approach.

Website: http://www.chicago.va.gov
Hospital/System: Katherine Shaw Bethea Hospital, Dixon

Contact: Dave Schreiner, FACHE
President and CEO
815-285-5501
dschreiner@ksbhospital.com

Project Title: Streamlining the Intake Process of Cardiac Patients in the Emergency Department

Summary: The goal was to improve turnaround times of troponin and EKGs within the cardiac patient population in the Emergency Department. The Chief Nursing Officer led this initiative, utilizing LEAN methodology with an interdisciplinary approach, focusing on streamlining patient flow. Strategies for improvement included revising the care delivery model during high volume times and shifting to a nurse initiated triage protocol, including STAT EKGs and STAT Labs.

The outcome was a 62% improvement in door-to-troponin results within 60 minutes, and a 32% improvement in door-to-EKG within 10 minutes. As a result, length of stay for cardiac patients decreased by 11 minutes and patients who left without being treated decreased to 1.59%.

Website: https://www.ksbhospital.com
Process Improvement–Clinical

Hospital/System: KishHealth System, DeKalb

Contact: Joe Dant
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Project Title: Improving the Health of the Population and Creating Equity in Access to Primary Care for Vulnerable Populations: Innovative Partnerships and Care Coordination

Summary: After identifying inequities with affordable access to primary care services and an uncoordinated system for vulnerable community populations, the hospital formed a community stakeholder group. Later, a formal partnership between the local hospital and university was forged to form a primary care clinic.

The goal was to improve community coordination, provide equitable care and improve access in a more cost-effective manner while reducing emergency department utilization for primary care. Upon opening in August 2009, the care clinic filled to capacity and exceeded the first year volume projections by over 100%.

Results from the first three years of operations included: improved care coordination between community organizations; increased staff—from one provider to four; and increased volume.

Website: http://www.kishhealth.org
Project Title: The "90 Minute" Performance Improvement Team

Summary: After learning of the "90 minute" standard of care for providing definitive treatment for cardiac patients, the team was charged with making recommendations to reach the "90 minute" goal. Records from 2006 found that in some instances, it took as long as 7.5 hours to get patients from the Emergency Department door to the cardiac care center door.

The hospital examined ED arrival times, ECG and EKG times, ED to Cath Labs transfer times, and balloon times to develop strategies to reduce the timeframes and improve care for both ground and helicopter EMS transports.

Through continued process improvement, the team improved the door-to-balloon time to an average of 115 minutes in 2012 with a best time of 34 minutes. Their record for ED door-to-balloon time (or total perfusion time) is 106 minutes traveling by ground and 107 minutes traveling by air. Work continues to meet the 90-minute goal.

Website: http://www.masondistricthospital.org
Hospital/System: Memorial Health System, Mental Health Centers of Central Illinois, Springfield
(Affiliate of Memorial Health System)

Contact: Charles D. Callahan, PhD, MBA, FACHE
Vice President of Quality & Operations
217-788-3135
callahan.chuck@mhsil.com

Project Title: Decreasing Outpatient Behavioral Health Wait Times Using Lean/Six Sigma Techniques and the Open Access Evidence-Based Model

Summary: The traditional behavioral health access model of calling for an appointment which is subsequently scheduled two to three weeks later, leads to prolonged wait times for clients thereby decreasing treatment compliance, staff productivity, and population health and increasing organizational and community costs. The project utilized Lean/Six Sigma techniques to streamline processes, eliminate duplicate data points and paperwork, and eliminate multiple appointments for behavioral health clients.

This resulted in a decrease in the client’s average wait time from 15.22 days from first contact to first appointment to 4.73 days across all behavioral sites of care. Some sites experienced wait times of only 1.2 days. A same day/walk-in assessment and service provision model increased the individuals’ engagement in service and thereby increased the first appointment show rates while decreasing the number of individuals who decide not to seek treatment or use the local Emergency Department for treatment.

Website: https://www.choosememorial.org
### Process Improvement–Clinical

**Hospital/System:** Memorial Hospital, Belleville  
**Contact:** Kerry Wrigley  
Director Quality Improvement  
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kwrigley@memhosp.com

**Project Title:** Admission Testing Center: Reduction in Time Required for Patient Throughput

**Summary:** Pre-operative/procedure testing for surgical, cardiac catheterization and scheduled C-section patients by the Admission Testing Center (ATC) was taking 2.25 hours on average (and up to four hours) to complete, creating significant patient and nursing dissatisfaction.

A four-day Lean Kaizen event followed baseline data collection and a multidisciplinary team was formed to reduce the throughput time for ATC patients. Initiatives focused on reducing patient throughput by approximately 18%, with a stretch goal of 24%.

On day one of the event, the average length of stay was 145 minutes (2.41 hours). As the week progressed, the average length of stay declined to 94 minutes (1.56 hours)—a 35% improvement. During the first six weeks of implementation, the average length of stay declined from an average of 135 minutes to an average of 109 minutes—a 19% improvement, with a maximum length of stay being 160 minutes (2.66 hours).

**Website:** [http://www.memhosp.com](http://www.memhosp.com)
Process Improvement–Clinical

Hospital/System: Memorial Hospital, Belleville

Contact: Kerry Wrigley
Director Quality Improvement
618-257-5328
kwrigley@memhosp.com

Project Title: Emergency Department: Optimizing Capacity with the Usage of Rapid Medical Evaluation

Summary: Emergency Department (ED) overcrowding has created patient throughput challenges with 2012 volume already exceeding budget. Left without being seen (LWBS) rates have been above the 2% Premier national benchmark. Time-to-provider minutes also were higher than desired, contributing to the LWBS rate of 3.6% and the discharged length of stay median time of 227 minutes.

Lean principles were applied to ED throughput processes by driving out waste and redesigning the system to create a smoother, more valuable process for all customers.

The front end ED visit process was redesigned with the implementation of rapid medical evaluation (RME). An internal waiting room was established for non-acute patients that allowed more beds to be available in the main ED.

A multidisciplinary team was formed and in under six months, time-to-provider decreased from 86 minutes to 28 minutes—a 67% improvement. The median length of stay for discharged patients decreased from 227 minutes to 147 minutes—a 35% improvement. LWBS decreased from 3.6% to 0.54%—an 85% improvement.

Website: http://www.memhosp.com
Process Improvement–Clinical

Hospital/System: Memorial Medical Center, Springfield

Contact: Charles D. Callahan, PhD, MBA, FACHE
Vice President of Quality & Operations
217-788-3135
callahan.chuck@mhsil.com

Project Title: *Lean/Six Sigma Methods Reduce Troponin Turnaround Time for Emergency Department Patients in a 500-Bed Tertiary Hospital Level I Trauma Center*

Summary: National Academy of Clinical Biochemistry (NACB) guidelines for Biomarkers of Acute Coronary Syndrome and Heart Failure emphasize a need for rapid turnaround time—within 60 minutes—for troponin results. Prolonged troponin test results may delay recognition of cardiac injury and the initiation of appropriate therapies.

A laboratory quality improvement project using Lean/Six Sigma (LSS) methodology reduced the in-lab turnaround time (TAT) for Emergency Department (ED) troponin results from a baseline of 55.4 (SD = 3.77) minutes to 33.2 (SD = 2.25) minutes. (Sigma scores before and after the improvements are 1.22 and 11.87 respectively.)

The improvement in troponin TAT allowed the laboratory to team with ED physicians averting a costly project, placing a Point-of-Care troponin platform in the ED, avoiding an estimated annual expense of $291,000.

Website: [https://www.memorialmedical.com](https://www.memorialmedical.com)
Process Improvement–Clinical

Hospital/System: Memorial Medical Center, Springfield

Contact: Charles D. Callahan, PhD, MBA, FACHE
Vice President of Quality & Operations
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callahan.chuck@mhsil.com

Project Title: Using Six Sigma Methodology to Improve Timeliness of Hip Fracture Surgical Repair

Summary: Medical center evidence pointed to a delay in surgery beyond 48 hours for hip fracture patients as a contributing factor to poor patient outcomes and increased mortality. A team comprised of academic and community physicians and hospital quality and process experts was formed to address the times utilizing Lean/Six Sigma methodology.

Using DMAIC process steps, preparing patients for hip fracture surgery in a timely manner improved from a 2.7 sigma process to a 3.7 sigma process.

Website: https://www.memorialmedical.com
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<tr>
<th>Hospital/System:</th>
<th>Methodist Medical Center of Illinois, Peoria</th>
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<tbody>
<tr>
<td>Contact:</td>
<td>Cindy Hale, RN, MS, CPHQ</td>
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<td></td>
<td>Director, Center for Analytics and Performance Excellence</td>
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<td>309-672-5986</td>
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<td><a href="mailto:chale@mmci.org">chale@mmci.org</a></td>
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<tr>
<td>Project Title:</td>
<td>Safety of Behavioral Health Patients in the Emergency Department</td>
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<td>Summary:</td>
<td>The medical center experienced a 115% increase in Behavioral Health (BH) patients presenting in the Emergency Department (ED) when the state hospital and two other local hospitals closed their BH units.</td>
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<td>In 2008, a separate BH area in the ED was developed to create a soothing and safe environment for these patients. Outcomes included a decrease in Security “standbys” for high-risk patients in the Main ED by 33%; and a decrease Length of Stay (LOS) for BH patients in the ED by 30 minutes.</td>
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<td>Partners in the project were successful in creating a significantly safer environment with no patient/staff injuries due to the environment since the new area opened. Unanticipated success occurred in reduced elopements (61%) and restraints (22%).</td>
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<td>Website:</td>
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**Website:** [http://www.mymethodist.net](http://www.mymethodist.net)
Process Improvement–Clinical

Hospital/System: Methodist Medical Center of Illinois, Peoria

Contact: Cindy Hale, RN, MS, CPHQ
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Project Title: Think Sepsis—A Multidisciplinary Approach to Identify Early Sepsis and Improve Patient Outcomes

Summary: In 2009, a multi-pronged approach involving all stakeholders was launched aimed at early identification and treatment to reduce inpatient sepsis mortality.

As a result of sustained and intense focus, inpatient sepsis mortality rate declined to 19% in 2009; 16% in 2010; and to 11% in 2011. The improvements in sepsis mortality can be attributed to an aggressive “Think Sepsis” campaign centering on a combination of innovative technological solutions to promote earlier recognition, improved protocols at various levels of care, accurate documentation, and intense and sustained sepsis training by all team members for early recognition and treatment of sepsis.

Website: http://www.mymethodist.net
Process Improvement–Clinical

Hospital/System: MetroSouth Medical Center, Blue Island

Contact: Gayle Toscano
Director of Performance Improvement
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Gayle_Toscano@metrosouthmedicalcenter.com

Project Title: Elimination of Elective Induction of Labor and Scheduled Elective Cesarean Section Before 39 Weeks Gestation

Summary: A performance improvement project was initiated to reduce the number of elective inductions and cesarean sections for >37 week to <39 week period gestational age group, with the goal of eliminating this practice. Analysis of facility data revealed an 11% rate from July 2009–June 2010.

Performance improvement plans included: development of a policy statement establishing dating criteria and acceptable gestational age timeframes for elective induction of labor and scheduled elective C-section; medical education (particularly OB-GYN practitioners); patient education; change management techniques; and Performance Improvement Department auditing. In calendar year 2011, the medical center achieved its goal of eliminating elective inductions and C-sections for the >37 week to <39 week gestational age group.

Website: http://www.metrosouthmedicalcenter.com
Process Improvement–Clinical

Hospital/System: NorthShore University HealthSystem, Evanston

Contact: Elizabeth Behrens, RN, MS
Vice President Quality Improvement
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ebehrens@northshore.org

Project Title: Combining Nursing Assessment, Electronic Medical Record Technology and Risk Stratified Interventions to Develop an Effective Falls Prevention Program

Summary: The project was to develop an infrastructure for a falls prevention program based on nursing fall risk assessment augmented by key information from the Electronic Medical Record (EMR) to support clinical practice standards and effective prevention strategies to decrease falls and fall-related injuries. The goal across all four hospitals was to attain and sustain fall rates and fall with injury rates below the National Database of Nursing Quality Indicators (NDNQI) mean for like Magnet units.

It was essential that staff believed that falls are preventable occurrences rather than inevitable events resulting from a patients’ actions. A multidisciplinary approach, focusing on appropriately using the Schmid scale to identify patients at fall risk and building supplemental alerts within the EMR, was utilized. This methodology allowed patients to be risk stratified into two groups; High Fall Risk and High Fall Risk with High Risk of Injury, necessitating varying levels of intervention.

Within six months of the education, activation of the EMR tool and implementation of risk group specific interventions, the corporate (four hospitals) fall rate dropped by 37% and the injury from fall rate decreased by 52%.

Website: http://www.northshore.org
Process Improvement–Clinical

Hospital/System: NorthShore University HealthSystem, Evanston

Contact: Ken Anderson
Chief Quality Officer
847-657-1820
kanderson1@northshore.org

Project Title: Undiagnosed Hypertension Project

Summary: In January 2011, utilizing the hospital’s system-wide electronic medical records (EMR), a family medicine physician studied data for the health system’s patients between the ages of 18 and 79 to identify those who may be at risk for hypertension.

Five algorithms were used to simultaneously query data from the EMR to identify adult patients with multiple elevated blood pressures who had never been diagnosed. If a patient was identified as being a candidate for hypertension, their individual physicians were notified, and patients were contacted to schedule an office visit.

Nearly 1,600 patients were identified as potentially having this condition without being diagnosed by their primary care physician. To date, more than 1,000 individuals have come in for testing. Approximately 40% of these patients have been identified as meeting the criteria for hypertension and are now receiving some form of treatment.

Website: http://www.northshore.org
Hospital/System: OSF Healthcare System, Peoria

Contact: William R. Scharf, MD
Physician Change Agent
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William.r.scharf@osfhealthcare.org

Project Title: Improving Obstetrical Care Through Organizational Collaboration

Summary: Infants born to mothers electively at a gestational age of 37-39 weeks are more likely to develop respiratory distress requiring mechanical ventilation. These children are more likely to have lifelong problems with asthma and other respiratory ailments. In central Illinois, there has been an increase in neonates requiring ventilator support as a result of elective deliveries.

A regional collaborative was created to improve the process and outcomes of obstetrical care. Using a systems approach, the rate of non-medically indicated inductions and C-sections decreased from 18% to 3.8%. The rate of infants requiring respiratory support did not change and the number of stillbirths did not increase despite a longer gestational age.

Website: http://www.osfhealthcare.org
Process Improvement–Clinical

Hospital/System: Resurrection Medical Center, Chicago

Contact: Heather Murphy
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Project Title: Reduction in Blood Culture Contamination Rates in the ED Through Use of Skin Cleansing and Antisepsis Prior to Blood Draw

Summary: July 2009-October 2011 baseline data for the blood culture contamination rate in the Emergency Department (ED) showed it was averaging 4.6%, above the national average of 3%. The ED staff had unsuccessfully tried various interventions to reduce the rate of contaminated blood cultures.

In September 2011, a multidisciplinary team was developed to address the issue of blood culture contamination. The approach included cleaning the patient’s skin prior to blood draw with a baby wipe and then prepping it according to standards using chlorhexidine.

Since the initiative began, the contamination rate for blood cultures has decreased to 3.4%.

Website: http://www.reshealth.org
Process Improvement–Clinical

Hospital/System: Rockford Memorial Hospital, Rockford

Contact: Evelyn Pagán
Vice President Quality and Performance Measurement
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epagan@rhsnet.org

Project Title: Eliminating Elective Deliveries Prior to 39 Weeks Gestation

Summary: According to Leapfrog survey results, the hospital’s rate of elective deliveries prior to 39 weeks gestation was higher than the national target.

In 2009, the hospital’s rate of elective deliveries prior to 39 weeks gestation was 25% or 78 out of 312 patients. In 2010, it was 10% or 27 out of 275 patients. In 2011, the rate was 0.47% or 1 out of 215 patients who electively delivered prior to 39 weeks gestation.

By focusing on elective deliveries prior to 39 weeks gestation, they have seen better birth outcomes, fewer NICU admissions and reduced patient medical complications. APGAR scores at five minutes are higher and fewer interventions at birth are needed.

Website: http://www.rhsnet.org
Process Improvement–Clinical

Hospital/System: Rush-Copley Medical Center, Aurora

Contact: Diane D. Homan, MD
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630-978-6208
Diane.Homan@rushcopley.com

Project Title: A Process Improvement Project Decreases Blood Culture Contamination Rates in the Emergency Room

Summary: The Emergency Room (ER) blood culture contamination rate remained above the national target even after implementing evidence-based practices. A blood culture collection team with designated staff from the ER was formed. They received education on proper blood culture collection protocols including the importance of following aseptic technique.

The new project was modified to enforce best practice by doing just-in-time education with staff identified to have collected a contaminated blood culture. Staff was required to complete an education module and practice was observed by the unit educator.

After the new project implementation, the blood culture contamination rate for the ER has remained below the national target for 12-consecutive months.

Website: http://www.rushcopley.com
Process Improvement–Clinical

Hospital/System: Rush-Copley Medical Center, Aurora

Contact: Diane D. Homan, MD
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Project Title: Early Elective Delivery: Decreasing Incidence of 37 to 39 Week Inductions and Cesarean Sections Without Medical Justification

Summary: In the 2010 reporting period (July 2009-June 2010), the medical center’s incidence of early elective deliveries without medical justification per Leapfrog definitions was 33.5%. A gap was identified between their internal data and Leapfrog reported data.

The Department of Obstetrics and Gynecology was educated on Leapfrog’s definition, rationale and data and they decided to align their internal definition and measurement with Leapfrog. Education on the risks of early elective deliveries was provided to practitioners and patients.

In October 2011, the medical center implemented a policy and process to reduce early elective deliveries. By the end of 2011, their early elective delivery rate decreased to 7.7%. The current rate is 2%; better than the Leapfrog 2012 goal of <5%.

Website: http://www.rushcopley.com
Hospital/System: Saint Anthony’s Health Center, Alton
Contact: Donna Rosenkranz
Director of Quality
618-474-4807
djros@sahc.org

Project Title: Core Measures—Appropriate Care for Every Patient Every Time

Summary: The goal was to eliminate all variances in the clinical process measures to ensure that patients who present with one or more of the four diagnoses under Core Measures receive 100% appropriate and timely evidence-based care.

A multidisciplinary team immediately reviewed each variance to determine the root cause and take action to prevent reoccurrence. Through real-time case identification and daily house-wide communication; weekly multidisciplinary meetings led by the CEO; ongoing education and constant communication with nursing and physicians; and enhancing their processes through systems thinking, the health center was able to reduce variances in each measure within months.

The goal of 100% appropriate care was maintained through zero variances for nine consecutive months for the heart failure and acute myocardial infarction patient population, and for eight consecutive months for pneumonia patients. The last surgery patient variance was in February 2012.

Website: http://www.sahc.org
Process Improvement–Clinical

Hospital/System: Saint Joseph Hospital, Chicago

Contact: Ben Matsumoto, MD
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ben.matsumoto@reshealthcare.org

Project Title: Outreach Mailing System to Improve Colorectal Cancer (CRC) Screening Rate in Outpatient Clinical Setting

Summary: The hospital recognized an urgent need to improve the current rate of colorectal cancer screening and to identify precancerous lesions at an earlier stage in the normal risk population.

In 2011, the hospital developed a CRC screening initiative involving 38 primary care physicians (PCPs), gastroenterologists and ICLOPS (clinical investigation software vendor) registry personnel.

First, strategies were developed to identify eligible patients for initial CRC screening. Next, outreach letters were sent out to encourage patients to schedule screening tests with their PCPs.

From this initiative, 57 patients were found to have precancerous adenomas and two patients were found to have colon cancer.

Website: http://saintjosephhospital.reshealth.org
Process Improvement–Clinical

Hospital/System: Silver Cross Hospital, New Lenox

Contact: David Schlappy
Vice President Quality and Medical Staff Services
815-300-7102
dschlappy@silvercross.org

Project Title: Improving Performance Using Evidence-Based Principles; Improving Discharge to Prevent Hospital Readmission of Heart Failure Patients

Summary: The hospital used evidence-based tools and interventions to decrease hospital readmissions by taking advantage of industry experts and utilized external collaboratives such as Preventing Readmissions through Effective Partnerships (PREP).

The hospital simultaneously participated in Project Better Outcomes for Older Adults through Safe Transitions (BOOST) and Project Re-Engineered Discharge (RED).

Tools included: 8–P assessments, teach back, dedicated RN Case Managers, home health visits, post-discharge follow-up, and local nursing home partnerships.

In 2010, the monthly 30-day readmission rate for Medicare heart failure patients was as high as 37%. After administration of the project, through the second quarter of fiscal year 2012, the 30-day Medicare readmission rate for heart failure patients was 13.7.

Website: http://www.silvercross.org
Project Title: Efforts to Eliminate Elective Deliveries Prior to 39 Weeks and Reduce Numbers of Elective Inductions

Summary: The decision was made to proceed with efforts to eliminate elective deliveries prior to 39 weeks and reduce numbers of elective inductions.

A variety of process improvements occurred including extensive physician and nursing education, a detailed induction policy and the implementation of an algorithm used by nursing for scheduled deliveries.

Since January 2011, there has been a 2% drop in Special Care Nursery admits.

Website: http://www.swedishamerican.org
Process Improvement–Clinical

Hospital/System: SwedishAmerican Hospital, Rockford

Contact: Kathleen Kelly, MD
Chief Medical Officer/Chief Quality Officer
815-489-4001
kkelly@swedishamerican.org

Project Title: *Emergency Department Case Management Program to Reduce High-Frequency Patient Utilization for Hospital and Community*

Summary: An Emergency Department (ED) Case Management program was developed to implement tactics focused on reducing ED avoidable ambulance transfers, ED visits and hospitalizations for patients who used the ED more than 10 visits per year.

For a defined group of high-frequency patients, interventions by a nurse-led case management program resulted in fewer ED visits to the hospital and other community hospitals, fewer overall ambulance runs and fewer inpatient hospital stays. These fewer ED encounters and hospitalizations translated to savings for the payers of care.

Point-of-service case management deployment tactics such as comprehensive case evaluation to identify care barriers, education of patients, families and providers, as well as patient linkage to a sustainable medical home, are a few of the key activities deemed effective at directing health care services for this population.

Website: [http://www.swedishamerican.org](http://www.swedishamerican.org)
Process Improvement–Clinical

Hospital/System: SwedishAmerican Hospital, Rockford

Contact: Jean Holm
Director Clinical Quality & Patient Safety
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Project Title: Prevention of Post-Operative Aspiration Pneumonia of the Inpatient Population

Summary: The goal was to decrease the number of patients negatively affected by experiencing a post-operative aspiration pneumonia which increases length of stay and leads to poorer overall patient outcomes.

After identifying key stakeholders, the team developed education plans for staff, patients and family which included thorough monitoring, risk assessments, dietary protocols, and aspiration precautions. Education specifically focused on a 30/30/30 rule: elevate HOB at 30 degree angle; patient must stay upright 30 minutes after meals; and reverse trendelenburg at 30 degrees.

The incidence of post-operative aspiration pneumonia decreased from 2.05-2.22% to 1.19%. Average number of cases per month pre-education 30/30/30 rule education was 6.58-7.3. Post-rule education showed an average number of cases per month of 4.0.

Website: http://www.swedishamerican.org
Process Improvement–Clinical

Hospital/System: Trinity Regional Health System, Rock Island

Contact: David L. Deopere, PhD
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Project Title: Bi-Directional Integration of Care Abstract

Summary: This project was designed to improve the total health care for patients of a community mental health center and the local Federally Qualified Healthcare Center through the development of an integrated system of care.

The target population was comprised of individuals with severe and persistent mental illness with a medical co-morbidity. Integrating the primary and behavioral health care provided a health care home for these individuals.

Patient scores reporting quality of life improvements rose from 38% to 82% (currently). Compliance rate for medical and behavioral health appointments improved from 74% to 81%. The percentage of patients seen in the primary-care setting rose from 0% to 100%, and the percentage of patients receiving a health risk assessment rose from 60% to 86%.

Website: http://www.trinityqc.com
Process Improvement–Clinical

Hospital/System: Vanguard MacNeal Hospital, Berwyn
Contact: Jan Machanis, RN, MSN  
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Project Title: Improving Mortality for the Septic Patient with a Resuscitation Bundle in the Emergency Department (ED)

Summary: A multidisciplinary committee found that despite an overall sepsis mortality rate similar to expected, there was significant variation in the care these patients received. Efforts to reduce mortality focused on sepsis recognition and treatment by using an ED protocol on appropriate fluid and antibiotic administration.

A “Sepsis Alert” process was created to promptly bring clinical resources to the patient bedside. A simple one-page order set was created to facilitate care. A focus study within the hospital’s MIDAS software system tracked process and outcome metrics. PDSA techniques were utilized to foster timely protocol and implementation of process improvements.

Overall sepsis mortality decreased by 20% with an absolute reduction in mortality from 25% to 20% with a p-value of 0.001. LOS decreased by 1.4 days. Overall sepsis diagnosis increased from an average of 34 cases/month to 44 cases/month. Usage of the Sepsis Alert protocol increased from <10% to >50%.

Website: http://www.macneal.com
Applicants

Process Improvement—Non-Clinical
Process Improvement–Non-Clinical

Hospital/System: Memorial Medical Center, Springfield

Contact: Charles D. Callahan, PhD, MBA, FACHE
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Project Title: Enhancing Hospital Safety Culture Through Use of Defect Huddle Incident Management System

Summary: Data from the AHRQ Safety Culture Survey indicated the need to improve mechanisms for incident capture, analysis, prioritization, and action. Based on Lean/Six Sigma methodology, the Defect Huddle was designed. It is a weekly 30-minute multidisciplinary team meeting where safety events, including near misses, medication errors, harm events, complaints/grievances, sentinel and/or regulatory issues, are presented and rated on a harm scale.

The resulting summary score indicates the improvement response: (1) localized departmental Plan-Do-Study-Act; (2) Multidisciplinary Failure Mode Effects Analysis (FMEA); or (3) formal Root Cause Analysis. The Defect Huddle also serves as a tracking repository of safety improvement efforts through conclusion.

Data from the first six months of Defect Huddle indicate that 97 safety events were reviewed, with 62% triaged as appropriate for FMEA, 31% for department PDSA “just do it” corrections and 7% for formal root cause analysis.

Website: https://www.memorialmedical.com
Process Improvement–Non-Clinical

Hospital/System: Memorial Medical Center, Springfield

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Project Title: Integration of Physicians into Lean/Six Sigma Performance Improvement Program via AMA PRA Category I-Accredited Executive White Belt Training Course

Summary: Recognizing the need to integrate physicians and other providers into its quality improvement program, Memorial Health System created an innovative training curriculum designed to educate physicians on Lean/Six Sigma tools and techniques while generating feedback and project suggestions. The course is four hours in duration and is accredited by the Accreditation Council for The Southern Illinois University School of Medicine for 3.75 AMA PRA Category 1 credits.

Thirteen sessions have been held at Memorial Medical Center and The Southern Illinois University School of Medicine, with 192 total attendees, including 133 physicians, 24 Memorial Health System Executive Leaders and 35 additional providers (PA, NP, etc.), all staying for the entire four hour session.

The course has generated numerous project ideas and has encouraged extensive physician participation on project teams such as Hip Fracture Management, Troponin Turnaround Time, Reduction in OR Waste, and ED Operating Model Redesign.

Website: https://www.memorialmedical.com
Process Improvement–Non-Clinical

Hospital/System: Methodist Medical Center of Illinois, Peoria

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Project Title: Implementation of a Safe Patient Handling Program

Summary: A Safe Patient Handling Program (SPHP) was initiated in 2006. A SPH vendor was chosen based upon employee product trial, evidence-based research with documented success rates, clinical support, and the guarantee of a ROI of 60% reduction in employee injuries.

A vendor-driven house-wide assessment was done to make recommendations regarding equipment purchases to ensure that patient care areas were given the right equipment for their patients.

Equipment was purchased and staff training took place January–April 2007. The program officially started May 1, 2007.

The ROI has surpassed the projected 60% reduction in employee incidents. Patient events of skin sheering and pressure ulcers were significantly improved, resulting in data below the national average.

Website: http://www.mymethodist.net
Process Improvement—Non-Clinical

Hospital/System: Silver Cross Hospital, New Lenox

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Project Title: Improving Continuity and Effectiveness by Reducing Nurse Turnover

Summary: Human Resources and the Nursing Leadership Team worked together using a PDCA for rapid cycle improvement to decrease turnover of registered nurses by refining the interview process and improving their orientation.

This project enhances the patient experience of care by providing continuity of caregivers and controls the cost of providing care by reducing the dollars spent repeatedly filling vacant nursing positions. Baseline turnover for fiscal year 2007 was 12.5%. In 2011, turnover was down to 8.9%.

Website: http://www.silvercross.org
Applicants
Readmission Prevention
Readmission Prevention

Hospital/System: Good Samaritan Regional Health Center, Mount Vernon

Contact: Michelle Darnell
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Project Title: *Timely Discharges and Reducing Readmissions*

Summary: Good Samaritan Regional Health Center’s medical unit required 4 hours, 18 minutes to discharge an inpatient once the discharge order had been written. A CQI+ team was sanctioned to reduce that time. The team used Lean/Six Sigma process improvement strategies to decrease both the hospital’s inpatient readmission rate and its inpatient discharge order-to-door time.

Discharge order-to-door time has been reduced in half and the improvement has been replicated hospital-wide. The unit has also realized readmission rate reductions. The March 2011 readmission rate of 17.68% for AMI/CHF/Pneumonia/COPD was reduced to 9.33% by April 2012. The hospital’s readmission rate for AMI/CHF/Pneumonia/COPD also has been reduced.

Website: [http://www.smgsi.com](http://www.smgsi.com)
Readmission Prevention

Hospital/System: Memorial Hospital, Belleville

Contact: Kerry Wrigley
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Project Title: Improving Heart Failure Discharge Outcomes—The Project RED Pilot

Summary: Using FOCUS-PDCA, the hospital identified an opportunity to decrease the 30-day readmission rate for heart failure patients.

In 2010, the rate for all payer patients was 32.4%. Through a partnership with Illinois Hospital Association, the facility implemented Project RED. The goal was to discharge patients with the tools and education necessary to improve health and compliance with treatments, and to keep them functioning in the community.

A Discharge Transition Coach role and an FTE were devoted to the program. Using methods such as intensive daily education with teach-back, an After Hospital Care Plan, and follow-up appointments and phone calls, the pilot population readmission rate dropped to 16.4% and the all facility rate to 23.1%. This led to a full roll out of the program and the development of a Nurse Practitioner led Heart Failure Clinic opening in June 2012.

Website: http://www.memhosp.com
Readmission Prevention

Hospital/System: Our Lady of the Resurrection Medical Center, Chicago

Contacts: Betsy Pankau Alyssa Howell
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Project Title: Reducing Avoidable Hospital Readmissions for the Heart Failure Population

Summary: To align the hospital ministry with the needs of the community and to reduce avoidable health care costs, a multifaceted approach to reducing the number of potentially avoidable hospital readmissions was developed for the heart failure population.

This approach included: a focus on in-hospital patient education and adherence to clinical best practices; expanded care coordination focused on discharge planning and post-discharge communication; and extensive patient assessment at the time of possible hospital readmission in the Emergency Department.

In March 2011, the 30-day all cause readmission rate peaked at 16.4%. A 28% rate reduction has been achieved with a rate of 11.8% in May 2011 with sustained improvement for the following eight months. In February 2011, the 30-day all cause heart failure readmission rate peaked at 41.4%. A 92.5% reduction in rate has been achieved with a rate of 3.1% in May 2011 discharges with sustained improvement for eight of the following nine months.

Website: http://ourladyoftheresurrectionmedicalcenter.reshealth.org
Readmission Prevention

Hospital/System: Proctor Hospital, Peoria

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Project Title: "Reduce CHF Readmissions by 20%" and Therefore Decrease the Hospital’s Financial Risk as Part of Healthcare Reform, Increase Compliance with CHF Core Measures and Provide a Structure to Reapply Similar Strategies Across All Diagnoses

Summary: Data suggests that the hospital has a three-year (2006-2009) CHF readmission average of 24.2%.

Using Six Sigma DMAIC methodology, the hospital implemented key intervention strategies and tools to reduce readmissions including: (1) developing a Discharge Bundle (checklist, new outpatient testing order form, patient home medication reconciliation sheet, prescriptions, etc.); (2) creating a patient education and discharge folder; (3) executing follow-up phone calls; (4) revising case management documentation; (5) revising CHF patient education materials; (6) utilizing a root-cause assessment tool for seven-day readmission cases; (7) creating MD CHF admission order set; and (8) partnering with the Agency on Aging for post-hospitalization community services.

During the first three quarters of the control phase, the hospital averaged 13.11% CHF readmissions. This can be compared to 16.71% for the top decile of Crimson cohort hospitals for the same time period.

Website: http://www.proctor.org
Hospital/System: St. Mary’s Hospital, Centralia

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Project Title: Reducing Readmissions CQI+ Team–Implementing Change Through the IHA Project RED Collaborative

Summary: The all-cause 30-day readmission rates for the hospital are higher than both the state and national average for all three quality indicators (AMI, CHF and community-acquired pneumonia). In January 2011, the hospital started a new CQI+ team to implement the Illinois Hospital Association (IHA) Project Re-Engineering Discharge (RED) Collaborative.

Working through the CQI process steps, sub-teams created process maps for each of the six target areas: medication reconciliation, patient/family education, internal and external communication, after-discharge follow-up, discharge instructions, and RED implementation.

Patient follow-up included a minimum of five phone calls during the 30-day post-discharge period. Health coaches generally make one home visit and often attend physician appointments with the patient in order to create seamless care coordination and ensure that the discharge plan of care is carried out. As a result, readmission rates in all categories are trending downward.

Website: http://www.smgsi.com