2013 Quality Excellence Achievement Awards

Recognizing Illinois Hospitals and Health Systems Leading in Quality, Innovative and Transformative Health Care

Delivering Quality with Distinction
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Overview

The Illinois Hospital Association (IHA) Institute for Innovations in Care and Quality’s (The Institute) third annual Quality Excellence Achievement Awards—Delivering Quality with Distinction—celebrates Illinois hospitals and health systems’ transformational achievements utilizing the Institute for Healthcare Improvement’s Triple Aim philosophy:

- Enhancing the patient experience;
- Improving population health; and
- Reducing health care costs.

Building upon previous years, 104 projects from 57 hospitals and health systems were submitted this year. IHA appreciates the expertise and commitment demonstrated by our members as well as our judging panel of 29 nationally-recognized quality improvement leaders, who carefully reviewed and scored each application. This year, three awards were presented, one in each of the following categories: Health Care System, Rural/Critical Access Hospital, and Urban Hospital.

To share these initiatives among members, The Institute has published this compendium that provides a synopsis of all project 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
Opens Spring 2014

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

AWARD CATEGORIES

- Health Care System
- Rural/Critical Access
- Urban

New in 2014: The Tim Philipp Award

A passionate advocate for quality improvement and patient-centered care, Tim Philipp, who died in May 2013 after a long battle with cancer, spearheaded the work of IHA’s Quality Awards. His work was greatly influenced by his unique perspective as a nurse, teacher and cancer patient. The *Tim Philipp Award for Excellence in Palliative Care* will honor excellence and innovation in palliative care.
2013 Award Recipients
Health Care System Award Recipient

Project Title: Lean Six Sigma Methodologies Reduce Hospital-Acquired Pressure Ulcer Prevalence by 79% in a Tertiary Medical Center

Hospital/System: Memorial Health System, Springfield

Summary: The goal was to reduce hospital-acquired pressure ulcer (HAPU) prevalence by 50% using Lean Six Sigma methodologies. Process defects were identified for pressure ulcer prevention (PUP), including correctly identifying at-risk patients, initiating PUP interventions, achieving minimal turning requirements, and effective care coordination across units and shifts. Key improvements include: 1) development of a "PUP Kit" consisting of a PUP Bundle and bedside communication tools; 2) creation of "Team-Up to Turn" approach at standardized times with support tools; and 3) enhanced role definition and training for unit-based Wound Ostomy Champions. Housewide hospital-acquired pressure ulcer (HAPU) prevalence rates for Stage I-IV ulcers have dramatically decreased from pre-intervention baseline average of 6.01% (Nov07-Aug11) to 1.28% (Jan13 - Jun13), a 79% decrease in HAPU prevalence rate and exceeding our initial goal.

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Urban Hospital Award Recipient

Project Title: SOS: Save Our Skin - A Pediatric Pressure Ulcer Prevention Program

Hospital/System: Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago

Summary: Infants and young children less than five years of age and children in ICUs are at the greatest risk for pressure ulcers. Other high risk pediatric populations are those with limited mobility, cardiac disorders with altered perfusion/oxygenation or lengthy operations greater than four hours. The most common site for pressure ulcers is the occiput in infants and toddlers and the sacrum in children. Occipital pressure ulcers have led to permanent alopecia, scarring, embarrassment, and body image disturbances. These injuries cause considerable harm, are painful and may lead to infection, sepsis, surgical intervention, and longer hospital stays. The cost of managing a single full thickness ulcer is estimated to be as high as $70,000. Hospital-Acquired Pressure Ulcers also impact reimbursement with the more severe ulcers (Stage III and IV) listed as one of the eight preventable conditions by the Centers for Medicare & Medicaid Services (CMS).

Most ulcers are preventable by identifying patients at risk and reliably implementing prevention strategies. In 2011, with the support of senior nursing and medical leadership, a Skin Care Committee was formed to identify the institution's Pressure Ulcer Prevalence Rate. Based upon data results, the committee developed a Pressure Ulcer Prevention Program (PUPP) modeled after the successful 2010 Children's Hospital Corporation of America (CHCA) Collaborative to decrease the hospital's Pressure Ulcer Prevalence Rate. The PUPP program includes: staff education on patients at risk, individualized preventative care measures and pressure ulcer assessment, staging and care. This quality improvement program also includes unit skin care champions and ongoing data collection to monitor for compliance, sustainability and improved patient outcomes.

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Rural-Critical Access Hospital Award Recipient

Project Title: “No One Falls” is Achievable: Patient Fall Reduction in a Critical Access Hospital

Hospital/System: Advocate Eureka Hospital, Eureka

Summary: In 2009, inpatient falls at the facility peaked. A fall prevention team was assembled. In 2010, the number of falls decreased by 50%. Post-fall huddles were initiated in late 2010, which greatly enhanced insight into the reasons patients fell. However in 2011, the number of falls increased and the need for a more sustainable change in culture, beyond a simple quality improvement “project” was identified. Corporate-sponsored fall prevention initiatives, such as prevention measure triggers based on fall score, campaigns to increase staff awareness of increased fall risk and a fall calendar on the Intranet, complemented and supported site-specific efforts to decrease our fall rate and improve patient safety.

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2013 Runners-Up
Health Care System Runner-Up

Project Title: Early Intervention of ST Elevation Myocardial Infarction (STEMI) through Pre-Hospital ECGs to Reduce Door to PCI Time and Improve Patient Outcomes

Hospital/System: OSF HealthCare, Peoria

Summary:
A systemwide opportunity was identified to improve the care of patients experiencing an ST elevation myocardial infarction (STEMI). The scope of the original project was to effectively reduce STEMI identification and treatment time, and included three system percutaneous coronary intervention (PCI) hospitals. As the STEMI project evolved, three non-PCI system hospitals were added to assure they participated in shortening the door-to-treatment time while routing the patient. This took extensive collaboration across a multidisciplinary team. Early diagnosis of STEMI reduces the overall door-to-PCI time by early activation of the Emergency Department, Cath Lab and air transport (when applicable), resulting in rapid intervention.

During the project, it became apparent that an opportunity existed to dramatically shorten the first patient contact to PCI time by allowing emergency medical services (EMS) to obtain and send an initial ECG to the nearest facility allowing for earlier activation of the STEMI system. Funding was provided to 48 EMS agencies and 14 affiliated and non-affiliated hospitals across Central and Northern Illinois to acquire the necessary software and hardware to transmit a pre-hospital ECG. For patients transported by several additional EMS agencies who technically could not apply the pre-hospital technology, the project team developed an education program to train the EMS agency staff in reading ECGs in the field.

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Urban Hospital Runner-Up

Project Title: Launching an Innovative Model of Care to Provide Quality Outcomes at a Lower Cost

Hospital/System: Northwestern Memorial Hospital, Chicago

Summary: Detailed data analysis at the hospital revealed that patients often readmit or return due to a lack of timely follow-up care and, more generally, a lack of access to appropriate outpatient care management. The hospital decided to develop a care model that aimed to improve the quality of discharge transitions after an inpatient stay or Emergency Department (ED) visit. This led to two goals: (1) ensure that all patients (who need it) receive access to outpatient care within seven days of discharge and (2) ensure that all patients have a primary care physician relationship.

A standardized follow-up appointment scheduling process has been introduced to provide patients access to outpatient care within seven days of discharge. For those patients without an established outpatient care relationship, a follow-up clinic, open three days weekly, was launched in December 2011 to stabilize patients, address psychosocial needs and bridge patients into a new medical home. The clinic expanded to a five-day a week operation in April 2013. Patients seen in the clinic have demonstrated a 37.5% reduction in 30-day ED return rates and 35.6% reduction in 30-day inpatient readmission rates compared to those patients scheduled but not seen in the the clinic.

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Rural-Critical Access Hospital Runner-Up

Project Title: Reduction in Health Care-Associated Clostridium difficile in a Rural Hospital Using a Collaborative Interdisciplinary Approach

Hospital/System: FHN Memorial Hospital, Freeport

Summary: The hospital’s objective was to reduce the number of health care-associated C. difficile (C. diff) infections below the national averages of 13 per 10,000 patient days using best practice guidelines, current literature and internal data. Literature documents that the two major reservoirs of C. diff in health care settings are infected humans and inanimate objects. Following national infection prevention guidelines alone, such as hand washing with soap and water, to guide efforts to reduce C. diff infections proved to be insufficient.

Through teamwork and cooperation amongst our Physicians, Staff Nurses, Infection Preventionist, and Environmental Services staff, their revised strategy included: eliminating unnecessary antibiotics; daily patient surveillance to identify patients at risk for developing C. diff infections (inclusive of patients admitted with diarrhea and those taking an antibiotic in combination with a proton pump inhibitor); ordering probiotics when applicable; and standardizing the cleaning of patient rooms. Integrating this collaborative and proactive approach yielded a 75% reduction in C. diff infections from baseline.

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Applicants By Project Topic
Care Coordination: Care Transitions
Care Coordination: Care Transitions

Project Title: Delivering COPD Care Across the Continuum

Hospital/System: UnityPoint Health - Methodist, Peoria

Summary: Only 20% of chronic obstructive pulmonary disease (COPD) patients at the hospital were properly diagnosed and staged with spirometry. Because of this, care was not evidence based, and there was poor coordination between sites of care. They developed a COPD program spanning the continuum of care. By careful attention to organizational dynamics, the hospital was able to do an initial implementation within five months. Key outcomes included improvement in proper diagnosis and staging of COPD, adoption of one evidence-based guideline for care, standard patient education across the continuum of care, and standards for treatment. This was done at multiple sites of care including ambulatory physician offices, the Emergency Department, inpatient, and home care within the organization. In addition, they developed partners at nursing homes, long-term acute care and medical supply organizations in the community.

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Care Coordination: Care Transitions

Project Title: Launching an Innovative Model of Care to Provide Quality Outcomes at a Lower Cost

Hospital/System: Northwestern Memorial Hospital, Chicago

Summary: Detailed data analysis at the hospital revealed that patients often readmit or return due to a lack of timely follow-up care and, more generally, a lack of access to appropriate outpatient care management. The hospital decided to develop a care model that aimed to improve the quality of discharge transitions after an inpatient stay or Emergency Department (ED) visit. This led to two goals: (1) ensure that all patients (who need it) receive access to outpatient care within seven days of discharge and (2) ensure that all patients have a primary care physician relationship.

A standardized follow-up appointment scheduling process has been introduced to provide patients access to outpatient care within seven days of discharge. For those patients without an established outpatient care relationship, a follow-up clinic, open three days weekly, was launched in December 2011 to stabilize patients, address psychosocial needs and bridge patients into a new medical home. The clinic expanded to a five-day a week operation in April 2013. Patients seen in the clinic have demonstrated a 37.5% reduction in 30-day ED return rates and 35.6% reduction in 30-day inpatient readmission rates compared to those patients scheduled but not seen in the the clinic.

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Care Coordination: Community Health
Care Coordination: Community Health

Project Title: County Mental Health Children’s Partnership

Hospital/System: Blessing Hospital, Quincy

Summary: The County Mental Health Children’s Partnership is a team of health, education and social service providers, parents and community members working together to develop an integrated system of care that will allow children in the county to live socially, mentally and emotionally healthy lives. A community needs assessment identified strengths, weaknesses, barriers, and gaps in services. Community work groups were established following a project logic model: interface between school and local system of care; early childhood psychiatric assessments and other diagnostic services; prevention and mental health systems including community awareness; utilization and coordination of inpatient mental health; integration and coordination of mental health and primary care; and mental health workforce development.

Key hospital staff were trained and two work groups were developed: Early Identification and Access to Mental Health Services and Specialty Assessment and Complex Needs. Interviews were completed with primary care providers to determine: if assessments were being completed for mental health and developmental screening; how referrals were made; how to decide when to refer; how parents were educated; physician willingness to have a mental health professional in their office setting; and physician recommendations of how to integrate primary care and mental health services for children. The work plan included: building a qualified, sufficiently staffed and adequately trained workforce; identifying children with social emotional problems through systematicwide screening; integrating of mental health services into primary care settings; sharing information across-systems; and maximizing support available to children and their families.

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Care Coordination: Community Health

Project Title: Immunization Rates Through Multidisciplinary Collaboration

Hospital/System: Norwegian American Hospital, Chicago

Summary: As of January 2012, two global immunization measures were established in which all patients discharged from acute inpatient care with a length of stay less than 120 days must be assessed for and offered the influenza and pneumococcal vaccines, as appropriate. In first quarter 2012, baseline compliance rates for influenza vaccination and the overall pneumococcal vaccination rates were lower than the organization’s expectation. A multidisciplinary team representing nursing, pharmacy and informatics collaborated to evaluate the hospital's vaccination rates, review current processes and assess the effectiveness of the current pneumococcal and influenza screening tools within the hospital information system.

Several opportunities for improvement were identified, thereby prompting changes to be made within the hospital’s health information system that included process changes via the use of rapid Plan-Do-Study-Act (PDSA) cycles. Another key strategy included advancing patient education on adult vaccinations where clinical pharmacists play a large role helping to address the needs of the hospital’s undeserved patient population. One year later, the hospital observed a 73% increase in vaccination rates for influenza and a 32% increase for the overall pneumococcal vaccination rate.

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Care Coordination: Palliative Care
Care Coordination: Palliative Care

Project Title: Advanced Care Planning in the ICU

Hospital/System: Silver Cross Hospital, New Lenox

Summary: Many Medicare patients with life-limiting illnesses had no documented advanced directive while in the ICU. The hospital’s aim is to address their physical, emotional and social needs by having a plan of care goal conversation in order to establish a written advanced directive. This project initially targeted Medicare patients in the ICU. It grew to include adult patients with advanced, serious illness in all areas of the hospital.

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Care Coordination: Palliative Care

Project Title:  Goals of Care Conversations as a Method of Coordinating Care: 25 Employees From Seven Departments Trained to Identify and Communicate Patients' Wishes for Hospitalization Outcomes and End-of-Life Care

Hospital/System:  St. Mary's Hospital, Centralia

Summary:  During 2011, the hospital joined the IHA Project Re-Engineering Discharge (RED) collaborative to reduce avoidable hospital readmissions. A Six Sigma level of 1.9 for the discharge process and medication reconciliation process showed that there was a lot of deviation. Process maps, swim lane diagrams and numerous other Continuous Quality Improvement plus tools were used to guide the team through a culture change. During an 18-month project period, new processes were implemented and the hospital opened a new department, Chronic Disease Management, to coordinate care for high risk patients to prevent readmissions for congestive heart failure, acute myocardial infarction, pneumonia, and chronic obstructive pulmonary disease.

In 2012, the hospital joined the Preventing Readmissions through Effective Partnerships (PREP) and Communication and Palliative Care (CPC) program. The CPC program was developed by the Section of Palliative Medicine at Northwestern University. The program provided expert mentoring and skills training for clinicians and health care teams to gain an indepth understanding of Goals of Care (GoC) conversations and how these open discussions represent opportunities to enhance patient choice and improve quality of life for patients with serious illness. Comparative data results revealed a 1.7% decrease in all-cause 30-day readmissions between 2011 and 2012.

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Care Coordination: Patient-Centered Care Initiatives
Care Coordination: Patient-Centered Care Initiatives

Project Title: A Rural Hospital’s Push to Move Patient Satisfaction From Better to Best in the Emergency Department

Hospital/System: Valley West Hospital, Sandwich

Summary: The patient experience as measured by patient satisfaction scores is an organizational goal. In the Emergency Department (ED), staff was challenged to move patient satisfaction scores from the 70th to the 90th percentile rank. To complete this challenge, the ED staff reviewed patient satisfaction data reported by Healthstream. Based on this feedback, the staff identified several behaviors they felt should be incorporated into daily routines, including: rounding, informing patients of delays and improving discharge instructions by reconciling medications with patients and families. Staff decided that improving the door-to-discharge times for patient stays would be a patient satisfier as well. The ED staff set into motion the performance expectations related to these behaviors that should be provided for each patient encounter. For the organization’s fiscal year, the ED has been able to maintain their satisfaction scores above the 90th percentile rank, with nearly half the scores between the 95th and 99th percentile rank.

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Care Coordination: Patient-Centered Care Initiatives

Project Title: Development of an Innovative Care Model for the Timely and Efficient Care of Patients who have a Potential or Confirmed Diagnosis of Cancer

Hospital/System: Saint Anthony's Health Center, Alton

Summary: After reviewing data from their cancer program, including data from an effective breast navigation program in place for four years, the hospital identified an opportunity to improve the efficiency and timeliness of the diagnostic and treatment planning processes. Improvement in timeliness of care leads to better patient outcomes resulting in a healthier population, reduced health care costs and an improved patient experience.

To achieve this, the hospital: allocated two full-time patient navigators to the oncology service line; implemented data monitoring; realigned the patient care processes around the patient (rather than the offices and departments); started daily navigation meetings with senior leadership in order to review status on navigated patients; implemented weekly multidisciplinary conferences for physicians to discuss real-time cases; and improved overall communication among team members and with patients. As a result of these interventions, the hospital reduced the average “Detection-to-Diagnosis” time from 15.7 days to 11.2 days, and reduced the average “Detection-to-Treatment” time from 47.6 days to 29.6 days.

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Care Coordination: Patient-Centered Care Initiatives

Project Title: Enhancing the Patient's Experience through an Innovative and Transformative Service Excellence Initiative

Hospital/System: McDonough District Hospital, Macomb

Summary: Data from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and patient satisfaction scores indicated the need to improve the patient experience to become the provider of choice for the primary, secondary and outlying market base. In collaboration with a consulting firm and a service excellence department, a program was developed and launched in January 2012, which includes elements of Lean/Six Sigma and a key focus on patient-centered care. The service excellence initiative includes cross-departmental project improvement teams, which deploy focused improvement on the patient experience, as well as improved employee and physician satisfaction and engagement. Weekly service huddles are required in each department that include a review of HCAHPS and patient satisfaction scores and a pre-determined improvement topic for huddle leaders to use at their discretion. The initiative encompasses every department across the patient's continuum of care, creating a uniform approach to patient-centered care resulting in improved patient satisfaction outcomes.

Continuous improvement projects, utilizing rapid cycle Plan-Do-Study-Act (PDSA) testing, were employed and proved effective in improving various areas such as environmental noise and the overall Emergency Department patient experience. Significant improvement of overall scores from calendar year 2011 to 2012 was achieved in seven of the eight HCAHPS domains (an average improvement of 7.4%) and in all areas surveyed for patient satisfaction. In the six areas surveyed for patient satisfaction, the hospital experienced an average improvement of 4.9% in top box scores.

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Care Coordination: Patient-Centered Care Initiatives

Project Title: Incorporating Patient-Centered Care Concepts in the Development of a Destination Center of Excellence for Total Hip and Knee Joint Replacement Patients

Hospital/System: Kishwaukee Hospital, DeKalb

Summary: The goal of this program was to create a Total Knee and Hip Joint Replacement Center of Excellence. Creating a service line model for patient-centered care and the patient experience takes a multidisciplinary team focused on outcomes to guide and achieve success. The program focused on 20 core elements that fell into four implementation categories—structure, people, processes, and results. Standards of practice and evidence-based clinical pathways were established that have a direct impact in thwarting off complications. This venture not only improved quality of care, but substantially impacted the cost of care. Multiple performance metrics were monitored to evaluate the impact on the patient experience.

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Care Coordination: Patient-Centered Care Initiatives

Project Title: Reducing Health Care Utilization and Improving Treatment Outcomes through Care Coordination and Bidirectional Integration of Primary and Behavioral Health Care for Patients with Serious Mental Illness and Medical Comorbidity

Hospital/System: UnityPoint Health - Trinity Regional Health System, Rock Island

Summary: The separation of physical and mental health services results in too many people going without their mental health needs being adequately defined and addressed. Additionally, there is substantial physical suffering and premature death for individuals with serious mental illness. In concert with the Institute for Health Care Improvement’s Triple Aim, the local Federally Qualified Health Center (FQHC) and Community Mental Health Center (CMHC) partnered to provide a patient-centered system of care through bidirectional integration of primary and behavioral health care patients.

The target population includes individuals with severe and persistent mental illness with a medical comorbidity. This integrated approach places a primary care provider into the behavioral health setting and embeds a behavioral health specialist into the primary care setting. This approach resulted in collaboration and coordination by establishing: 1) physical examinations of all recipients; 2) protocol for referral of high-risks individuals; 3) procedures for co-management and stabilization of patients; 4) a referral process for follow-up care; 5) integrated treatment planning; and 6) increasing the capacity of the FQHC to provide proactive follow-up and management of patients with behavioral health conditions in the primary care setting.

This collaboration improved the total health care of the patient through the development of an integrated system of care.

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Care Coordination: Patient-Centered Care Initiatives

Project Title: Sustained Nutritional Improvement in Pediatric Cystic Fibrosis (CF) Patients

Hospital/System: Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago

Summary:
A body mass index at or above the 50th percentile is associated with better lung function and survival in children with CF. A long-term quality improvement effort has led to superior nutrition at the Children's Hospital CF Center. The hospital joined an improvement collaborative, funded by the Cystic Fibrosis Foundation, from 2002-2004 and implemented consensus conference recommendations through process improvements.

Plan Do Study Act cycles and frequent data review have continued since 2004, such as updating algorithms when a new guideline was published. It saw significant improvement in nutrition during and after the collaborative (supplemental data). While improvement seen during short term collaboratives can “drift”, long term success is due to training team members in QI methods, regular data review, leadership development, and patient and family involvement. These strategies can be widely applied in health care micro-systems caring for chronic illness populations.

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Care Coordination: Readmissions
Care Coordination: Readmissions

Project Title: Decreasing Heart Failure (HF) Readmissions with an Advanced Practitioner Nurse (APN) Lead Heart Failure Clinic

Hospital/System: Advocate South Suburban Hospital, Hazel Crest

Summary: The heart failure program was developed in April 2011. Protocols and standing orders were developed with the American College of Cardiology Foundation/American Heart Association and Heart Failure Society of America guidelines, in collaboration with the medical director. Direct care is provided in the Heart Failure (HF) Clinic by a nurse practitioner (NP). The first visit consists of thorough education regarding heart failure disease process, medications, daily weights, sodium and fluid restriction, activity level, and self-care guidelines. Follow-up visits are based on the need for titration of medication and compliance assessment. Visit notes, medication list and any lab results are faxed to primary physician and cardiologist.

At present, the clinic has 110 active patients. Patient population consists of 20 to 90 years old, primarily males of all races excluding: dialysis, hospice, nursing home, and home care patients. Most patients are Medicare or Medicaid, 30% are insured and 10% uninsured.

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Care Coordination: Readmissions

Project Title: Empower the Community, Other Health Care Providers and Patients with the Understanding of Heart Care Diagnosis and Treatment in Order to Prevent Readmissions

Hospital/System: Anderson Hospital, Maryville

Summary: The hospital identified the need for education within the community to help keep its patients maintaining healthy lifestyles and to prevent hospitalizations. The goal was to empower the community, other health care providers and patients with knowledge of managing heart care disease.

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Care Coordination: Readmissions

Project Title: Heart Failure Care Transitions from Hospital to Home in Cooperation with Several Illinois Hospitals

Hospital/System: St. John's Hospital, Springfield

Summary: The heart failure program began in 1995. The hospital developed a multidisciplinary heart failure clinic and inpatient team. In 2010, the medical staff supported each patient receive congestive heart failure (CHF) education with transitions of care in a nurse-run clinic one week after discharge and a telehealth scale for 90 days post-discharge.

The hospital received a Health Resources and Services Administration (HRSA) grant to improve CHF care to rural areas around the state. They built relationships by developing a heart failure toolkit and distributing it to referring hospitals, explaining they could participate by selecting a nurse and physician champion. Once selected, the hospital educated nurses to provide inpatient education and the one week follow-up clinic. They presented program parameters along with the telescale protocols to hospital administration and medical staff to gain long-term support. Participants were invited to the hospital to observe how the program worked and then planned implementation in their specific hospital. Twelve hospitals around Illinois are participating in the hospital's CHF program.

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Care Coordination: Readmissions

Project Title: Heart Failure Readmissions

Hospital/System: Edward Hospital, Naperville

Summary: The hospital aimed to reduce preventable hospital 30-day readmissions for heart failure (HF). An interdisciplinary performance improvement team was assembled to determine interventions needed to reduce the readmission rate. Interventions initiated included: ensuring follow-up appointments are scheduled within seven days post discharge; an APN staffed post-discharge at the HF clinic; an electronic LACE (Length of stay, Acuity of admission, Comorbidities, Emergency Department visits) tool to screen high risk readmission patients; participation in the Hospital Program Peak Performance (HP3) statewide initiative; ensuring patients are discharged with a home health visit; hardwiring the use of teach-back; sharing educational materials with community skilled nursing facilities; assembling a community task force; and daily real-time audits of heart failure education documentation.

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Care Coordination: Readmissions

Project Title: Knowledge and Empowerment Across the Continuum For Effective Disease Management and Reduction of Readmissions

Hospital/System: St. Joseph's Hospital, Breese

Summary: A gap analysis was conducted. Key themes emerged in this analysis such as inadequate preparation for self-management of medical conditions and gaps/concerns across the continuum including: communication, medication reconciliation, and variations in knowledge sets of caregivers. Through continued research, observations and work sessions, the following strategies for change were identified and implemented: development of a care path to guide members of the hospital team in preparing the patient and family for discharge; resource materials; weight logs; diet information; appointment calendar; red/yellow/green zone magnets for home display and a reference for family members, primary care physicians and office staff, nursing homes, assisted living centers, and home health agencies.

Teach-back methodology has been taught across the organization to better assure patient and caregiver understanding of important information. Colleagues are invited to participate in readmission huddles. Partners in Caring introductory meetings were held for area home health agencies, assisted living centers and nursing homes. A physician champion educated hospital medical staff, at large. Visits were made to area meal sites to educate staff on reduction of sodium content in meals served at senior citizen sites and meals on wheels programs. Collaboration led to co-sponsored community education programs. The improvements in processes and assessment skills have resulted in measurable successes including a reduction in readmissions and overall first admissions to the hospital.

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Care Coordination: Readmissions

Project Title: Readmission Rate Reduction Through Team Collaboration and Patient Partnership

Hospital/System: Pekin Hospital, Pekin

Summary: The hospital’s multidisciplinary team utilized Plan-Do-Study-Act (PSDA) with evidence-based practice research, Centers for Medicare & Medicaid Services Hospital Engagement Network guideline recommendations, and patient feedback to create a Care Transition Program to reduce all cause 30-day readmissions by 20%. The program provides individualized multi-faceted support to the patient from admission and extends beyond discharge to improve the patients' self-managed care and outcomes.

The Care Transition Coordinator, with the assistance of the physicians, case managers, social workers, pharmacy staff and outside agencies, assists the patient with follow-up appointments and medication management, weight and blood pressure monitoring, and improved education. Through the team collaboration and patient partnership, the hospital reduced their all cause 30-day readmissions rate by approximately 55% in nearly one year.

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Care Coordination: Readmissions

Project Title: Reducing 30-Day Readmission Rates Through Targeted Population Interventions

Hospital/System: University of Chicago Medical Center, Chicago

Summary: Since 2010, the academic medical center has been supporting a program to reduce 30-day all cause readmission rates by targeting efforts on a subset of patient populations each year. By breaking down the medical centerwide, all-cause readmission rate, they are able to target resources and work to make significant advancements in a relatively short period of time. Each workgroup is managed by the clinical effectiveness department but staffed by the clinical teams that understand these patient populations best. This allows the institution to quickly identify issues with care coordination and understand weaknesses in their current processes. With clinical effectiveness leading the groups, the institution is able to spread successful changes and provide cross-collaboration across workgroups when similar situations arise.

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Care Coordination: Readmissions

Project Title: Reducing Heart Failure Readmissions: A Cross-Continuum Approach

Hospital/System: Presence St. Mary's Hospital, Kankakee

Summary: The goal was to provide an avenue for proactive heart failure patient care to reduce preventable readmissions. This was done by engaging hospital care management, cardiac rehab staff and the post-acute care nurse navigator (nurse liaison between hospital, long-term care and home care entities within the county market) to: schedule follow-up physician appointments; provide 1:1 inpatient education; make follow-up calls at 24-72 hours post-discharge and again at 25-30 days post-discharge; allow patients’ the opportunity to ask questions by employing the teach-back approach; and promote in-home follow up and teaching reinforcement with home care programs designed for patients with heart failure.

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**Care Coordination: Readmissions**

**Project Title:** Reducing Readmissions: A Strategic Initiative to Look at All Preventable Readmissions and How the Hospital Can Make a Difference in the Health of the Community

**Hospital/System:** Cadence Health, Winfield

**Summary:** Phase I consisted of developing and implementing protocols for cases presenting to the Emergency Department (ED) within 30 days of hospital discharge. Interventions included identifying potential readmissions during ED triage and paging key team members with every potential readmission. The teams and the ED physicians collaborated on most appropriate patient disposition, while community resources, home health and supportive services were arranged from the ED.

Phase II consisted of determining readmission risk and providing a detailed transition plan to every inpatient; contacting moderate to high-risk cases by phone post discharge to review transition plan; and promoting in-hospital pharmacy consults, referrals to home care and palliative care. A readmission flag was implemented on the computerized chart. A dashboard of metrics was developed to track progress.

Phase III featured a collaborative with key skilled nursing facilities (SNFs) to develop standard practice and processes. Interventions included rolling out best practice tools and reviewing handoff processes. Monthly scorecards were reviewed with all SNFs. Gatekeepers at each facility were identified. A capabilities checklist was made available for providers in the ED for the SNFs. Transfer documents were standardized and sent with each patient outlining key clinical information.

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Care Coordination: Readmissions

Project Title: Tackling ED Recidivism: Empower and Engage Your Organization

Hospital/System: Advocate Good Shepherd Hospital, Barrington

Summary: The hospital’s individualized care planning (ICP) approach for the high utilizer Emergency Department (ED) patient population is a comprehensive patient-centered program that enhances the patient experience and improves the organization's fiscal health and responsibility. This project engages front line staff through senior leadership to provide the resources, referrals, support, networking, and appropriate treatment for patients.

The ED front line team members are actively involved in the process of recommending patients for an individualized plan of care. The interdisciplinary ICP team reviews each case and involving the patient's own physicians, regardless of affiliation. The patient and family are involved (when possible) in the development of his/her plans of care. Goals for care are safety driven and holistic. Ongoing follow-up with the patient to ensure compliance with discharge health care instructions is an important factor. Communication with the entire ED team is vital to ensure that the plans of care are fully implemented upon the patient’s arrival. They are routinely reviewed for appropriateness and updated based on patient’s need.

The program includes more than 250 patients. The hospital has seen a consistent reduction average for ED revisits between April 2012 - April 2013 at 68% across four demographic patient groups. ED readmissions have been reduced 72% (on average). The projected cost savings analysis for ED recidivists is $1,421,088 and for ED readmissions is $939,934. The rest of the system Emergency Departments are currently adopting this program.

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Operational Excellence: Employee Health and Wellness
Operational Excellence: Employee Health and Wellness

Project Title: Improving Job Performance and Resident/Family Satisfaction by Reordering Priorities Through Daily "How I Make a Difference" Statements while Continuing to Acknowledge the Routine Disruptive Nature of Daily Duties and Expectations

Hospital/System: Hillsboro Area Hospital, Hillsboro

Summary: The hospital’s staff is primary in its vision to continue to be recognized as a leading provider of health and wellness services. Assisted Living Department leaders addressed staff well-being because female staff often struggles with family and financial pressures. Simply at the end of shift, all staff write at least one way in which he/she made a positive difference that day. This refocuses the staff to reflect on his/her value to the resident and their family. Outcomes are supported by data showing fewer late arrivals, better attendance and increased employee engagement. In addition, resident and family satisfaction surveys reached their highest levels, and the hospital’s overall mean scores placed it in the state’s upper rankings.

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Operational Excellence: Employee Health and Wellness

Project Title: One Rural Hospital's Business Line: Staff Wellness and Community Health

Hospital/System: Hillsboro Area Hospital, Hillsboro

Summary: Because reducing health care costs requires the public’s understanding and engagement to stay healthy, this rural hospital has taken a leadership role in promoting wellness to both the hospital staff and the community it serves. Caring about and taking responsibility for the community's health has become an essential business line.

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Operational Excellence: Employee Health and Wellness

Project Title: Wellness EDGE: Embracing the Future of Our Community and the Role We Play in Keeping Ourselves, our Friends, and our Neighbors Healthy and Strong

Hospital/System: Kewanee Hospital, Kewanee

Summary: The hospital’s project was to build a sustainable culture of wellness continuing its mission of improving the health of those they serve. Through its work and dedication, the hospital’s Wellness EDGE program reaches the farthest boundaries of the communities it serves to: increase the overall health status of its employees; improve productivity; decrease presenteeism and absenteeism; lead health and wellness in its communities; and lower health care costs.

Presenteeism: defined as the measure of lost productivity and associated cost due to employees attending their jobs but not being fully engaged and productive because of personal health and life issues and distractions.

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Operational Excellence: Infrastructure
Operational Excellence: Infrastructure

Project Title:  “Closing the Loop” on Unexpected Results

Hospital/System:  Northwestern Memorial Hospital, Chicago

Summary:  Hospital research revealed that there is no well-accepted, proven model for a highly reliable “closed-loop” system for the communication and documentation of unexpected (non-critical) radiologic findings such as incidental pulmonary nodules and renal masses. A lack of timely follow-up by the appropriate caregiver can result in delayed or missed treatment and adverse patient events. Third-party technology solutions that assist with these result notifications can be cost-prohibitive and inflexible. In an environment with increasing volume and time pressures, even the most well-intentioned interpreting radiologists and referring physicians are likely to miss the reporting, tracking, reading, and follow-up of every single unexpected finding.

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Operational Excellence: Infrastructure

Project Title:  Code STEMI

Hospital/System:  Clay County Hospital, Flora

Summary:  The Emergency Department recognized an opportunity to improve patient flow for cardiac patients. Documentation revealed time to first electrocardiogram at 22 minutes, which was not compliant with the Centers for Medicare & Medicaid Services guidelines. Also, the time from patient arrival to patient transfer (to a higher level of care) was 308 minutes. A cardiac advisory board was created to address areas for improvement. Members from different ancillary departments and from our neighboring facility were involved in order to have continuity throughout the organization. The board’s primary goal was to improve the treatment and transfer times for patients having an ST Elevated Myocardial Infarction (STEMI).

The team created a call system and protocol named Code STEMI. One month after Code STEMI implementation, initial electrocardiogram upon arrival times improved from 22 to 11 minutes. The time to treat and transfer a patient to the appropriate higher level of care significantly shortened from 308 to between 27-98 minutes. The transfer time goal is 30 minutes or less with regards to specific internal variables such as confirmation of diagnosis with the cardiologist, staffing, transportation and ancillary support. External threats include poor weather conditions that limit air and/or ground transport. Even with these variables, the hospital was able to decrease arrival to transfer times by at least 210 minutes.

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Operational Excellence: Infrastructure

Project Title: Code Stroke Initiative

Hospital/System: Silver Cross Hospital, New Lenox

Summary: The hospital applied for the Joint Commission certification as a Primary Stroke Center. In order to achieve certification, performance data was collected and analyzed. An opportunity for improvement in partial thromboplastin time (PTT) results available to clinicians in 45 minutes was identified. The rapid response team that was already in place was expanded to include interventions specific to patients with signs and symptom of stroke, Code Stroke. Turnaround times improved dramatically and were sustained.

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Operational Excellence: Infrastructure

Project Title: Decreasing Delay in Electronic Census Discharge in a 500-Bed, Academically-Affiliated, Tertiary, Level I Trauma Medical Center

Hospital/System: Memorial Medical Center, Springfield

Summary: Inpatient discharge process efficiency is a key contributor to reducing hospital length of stay and improving patient flow. By reducing the time interval from when a patient physically leaves the unit on discharge to the time the individual is removed from the electronic inpatient census, the hospital regains valuable minutes of bed turnaround time and patient flow efficiency. Also, timely electronic census discharge mitigates potential legal liability for having patients discharged to the community while remaining in the hospital census.

Through a series of interventions using Lean Six Sigma Define, Measure, Analyze, Improve, Control (DMAIC) methodology, the mean time differential between actual discharge and census discharge was reduced by 92% (from 55 minutes to less than five minutes) and the variation (standard deviation) by 75% (16 minutes to four minutes) between August 2012 and May 2013.

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Operational Excellence: Infrastructure

Project Title: Defect Huddle Safety Event Priority Scoring Matrix: A Systematic Approach to Triaging Safety Events for Effective Action

Hospital/System: Memorial Health System, Springfield

Summary: The Safety Event Priority Scoring matrix provides a systematic approach to triaging actual and near-miss safety events for improvement action. This tool is a core component of multidisciplinary Defect Huddle meetings to analyze and prioritize improvement activities for a variety of events/issues/defects/complaints/concerns. The scoring matrix reflects four evaluation factors: current clinical outcome of the patient affected by the process error or defect; potential for adverse outcome from this error for a future patient; patient/family satisfaction with resolution of the event; and scale, or health system breadth of the event.

Each of the four factors is appraised on a three-point Likert-type scale, with discrete criteria for each point specified. Once scored, the event is triaged according to the total score. Lower severity events (scores 5 or less) are referred to the department level for improvement utilizing the Plan-Do-Study-Act methodology. Events that score 6-8 are referred for a Failure Modes and Effects Analysis (FMEA). The Defect Huddle then determines if the work done by the FMEA team has sufficiently reduced the likelihood of a reoccurrence, or whether a belt project needs to be assigned. Those events that score 9-12 are referred for a full Root Cause Analysis and are reported to the Quality and Safety Management Committee of the Board of Directors.

The use of the Safety Event Priority Scoring matrix has created a response system for all events. It has also created an accountability system that assures that the appropriate follow-up actions occur and learning is integrated across the organization.

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Operational Excellence: Infrastructure

Project Title: Door-to-Balloon Lean Rapid Improvement Event

Hospital/System: Rockford Health System, Rockford

Summary: Utilizing Lean tools, the door-to-balloon process was scrutinized and modified to reduce unnecessary duplicative processes and reduce time. This was achieved by modifying the staff call-in process and supplies standardization. A single simultaneous call to the interventionalist and all required staff was implemented. Creating a standardized ST elevated myocardial infarction (STEMI) supply pack eliminated the need to search in several areas for necessary patient care items. Medication standardization was done for necessary medications and standard work process provided staff a road map for efficient patient care.

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Operational Excellence: Infrastructure

Project Title: Enhancing Magnetic Resonance Imaging Safety: A Systemwide Approach to Improving Environmental and Cultural Safety in High Field Strength Imaging

Hospital/System: Memorial Medical Center, Springfield

Summary: Root Cause Analysis performed in response to a near-miss safety event (metal stool) in the 3.0 Tesla Magnetic Resonance Imaging suite identified that there was opportunity to improve MRI safety practices across the health system. A Lean Six Sigma team, comprised of senior leaders, physicians and staff from five regional imaging sites, was charged to identify and improve safety care processes. Using American College of Radiology’s MRI Safety White Paper as a roadmap, 43 action items were engaged focused on leadership, staffing, operations, and facility design elements.

Multiple safety enhancements were made including: the development of a systemwide MR Safety Policy; enhancement of the screening process for patients, family and staff; establishment of a Physician MR Safety Officer at each facility; development of a fire and emergency response plan for the MR suites; additional staffing to assure two staff were assigned to the MR suite at all times; and development of an annual safety competency for all staff with the potential for encountering the MR suite. Also, physical environment enhancements were made to clearly demarcate the four distinct MRI safety zones; and physical barriers were installed in zones three and four. The control plan included monthly unwarned physical site inspections using a new MR environmental audit form. Audit trend data indicates 100% compliance across all sites of care for all inspections and is presented to the Board Quality and Safety Management at recurring intervals.

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Operational Excellence: Infrastructure

Project Title: Improved Turnaround Time and Reduction of Manual Processing Waste for Laboratory Complete Blood Count Testing

Hospital/System: Memorial Medical Center, Springfield

Summary: The Complete Blood Count (CBC) is the single most commonly ordered test in the medical center laboratory. Modern hematology diagnostic machines analyze blood cells at a high level of accuracy that rarely requires further “manual differential review” by trained laboratory professionals. Nonetheless, the medical center’s laboratory maintained reliance on a complex but outdated set of algorithms developed over many years to flag blood samples for manual review. This practice produced a baseline manual review rate of 51%, well above current evidence-based benchmarks, resulting in excessive diagnostic result turnaround time (TAT), delays in patient care and inflated labor costs for short-supply lab personnel.

Lean Six Sigma methodology was used to design and verify a new algorithm that reduced CBC manual review rate by 63% (51% to 19%), dropped average TAT by 52% (46 to 22 minutes), and reduced required labor by 3.3 FTE, for annualized savings of $260,000.

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Operational Excellence: Infrastructure

Project Title: Improving Length of Stay and Care Delivery for Patients with Severe Psychoses through a Three-Pronged Lean Six Sigma Intervention

Hospital/System: Memorial Health System, Springfield

Summary: When compared to national severity adjusted benchmarks, data revealed a high average length of stay (ALOS) for psychiatric patients hospitalized with acute severe psychoses (DRG 885). High ALOS may reflect delays in care delivery, or opportunities to expand unit access to additional patients given regional closures of inpatient psychiatric facilities. A team used Lean Six Sigma to design a three-pronged process improvement using: 1) an assertive empirically-based antipsychotic medication protocol; 2) crisis beds and partial hospitalization to aid care transitions; and 3) twice weekly formal structured team rounds. Over a three-month pilot period focused on one high-volume physician champion's admissions, a 40% reduction in ALOS (from 13.0 to 7.8 days) was observed, with no negative clinical or service outcomes.

Given historical volumes and cost/case for this DRG, standardization of this process to all admitting physicians would yield $2 million in annualized cost savings, as well as provide additional inpatient capacity for 400 patient admissions per year. Physician satisfaction improved due to more efficient patient rounding and a reduction in off-hour "problem" calls. Overall, this project represents a true Triple Aim victory of improved clinical quality, reduced cost and better access/service.

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Operational Excellence: Infrastructure

Project Title: Improving Patient Satisfaction with Visual Management in the Emergency Department

Hospital/System: Kishwaukee Hospital, DeKalb

Summary: In the Emergency Department (ED), staff were challenged to move patient satisfaction scores. After staff began Lean management training, they decided to use a visual management technique to respond to patient needs, improve satisfaction scores and enhance patient safety. Rounding lights with a 30-minute timer were mounted outside of every patient room in the ED. After a patient had been rounded on, the staff member taps the light. If the light is off, it serves as a visual queue that the patient needs to be rounded on again.

The rounding focuses on patient needs such as repositioning, personal needs, pain, and bathroom assistance. This rounding gives staff the opportunity to inform patients of delays in care or treatment, therefore, keeping the patient/family informed about the plan of care.

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Operational Excellence: Infrastructure

Project Title: Improving Surgical Safety: Design and Implementation of a Surgical Prep List Using Lean Six Sigma Methodology

Hospital/System: Memorial Medical Center, Springfield

Summary: Improving surgical and procedural safety is a national health care imperative and a hospital operational priority. A Lean Six Sigma project focused on design, implementation and verification using Define, Measure, Analyze, Design, Validate (DMADV) of an empirically-based, pre-surgical safety checklist to standardize key elements of care. The project transformed an unmanageable and poorly utilized 60-item laundry list, into a streamlined Surgical Prep List and electronic hand-off tool that meets the National Patient Safety Goal for safe patient hand-offs and WHO Universal Protocol Safety Checklist requirements.

Prior to implementation, compliance with the former checklist produced a 10% defect rate (2.79 sigma). Post-implementation, over a five-month period, the hospital maintained a zero defect rate (> 6.0 sigma) for a significant Universal Protocol safety yield. In addition, the new, safer process is more efficient, producing a 30% reduction in Pre-Operative Holding Area wait time variability (UCL 166 minutes reduced to 116 minutes) and 10% reduction in average hold time, recapturing an average of 10 hours of OR delay daily.

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Operational Excellence: Infrastructure

Project Title: Increasing Physician Productivity and New Patient Access to Outpatient Psychiatric Care through Parallel Patient Scheduling

Hospital/System: Memorial Health System, Springfield

Summary: Psychiatrist physician time is the most expensive labor allocation in the hospital’s outpatient behavioral health setting. In seeking to increase psychiatrist productivity to decrease operational costs, a Lean Six Sigma project was initiated to decrease the number of outpatient appointment no-shows and cancellations. Intervention focused on moving from a traditional model—appointments scheduled every 20 minutes—to a new parallel appointment model.

Pilot results indicated a 15% improvement in no-show rates, resulting in a 47% reduction of days to first available appointment (37.5 days to 20 days; benchmark=19 days). Patient satisfaction remained stable during the pilot. Overall, this intervention improved physician productivity, improved clinic financial operations through reduction in non-productive time and enhanced access for new patients through reduction in waits/delays for first appointment.

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**Operational Excellence: Infrastructure**

**Project Title:** Making Every Alarm Actionable: Preventing Failure to Rescue Events in Telemetry

**Hospital/System:** NorthShore University HealthSystem, Evanston

**Summary:** The goal was to develop and implement a systemwide standardized approach to a telemetry alarm management program through examining current telemetry standards and alarm prioritization settings, while including staff, physician and leadership engagement strategies. An extensive failure mode and effects analysis was conducted including: a baseline inventory of all alarm settings in all med-surg areas across four hospitals; identification of critical life alarms and inventory of settings; pager integration and types of alarms activating pagers; staff interpretation of required action once pager is activated; equipment associated with telemetry leads; baseline staff competencies of licensed and unlicensed assistive personnel; unit configuration; and policy oversight.

The team chose the general med-surg floor as the initial focus since the staff-to-patient ratio is greater than in the critical care areas, the variable as to why the alarms are triggered are not as complex and the number of patients who are being monitored is the largest. The comprehensive approach considered human factors such as current behaviors and anticipated behavior changes, technology requirements and limitations, and policy requirements to support practice changes. Lessons learned are currently being applied to all PACUs and ICUs.

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Operational Excellence: Infrastructure

Project Title: Microbiology Clostridium difficile Testing

Hospital/System: Silver Cross Hospital, New Lenox

Summary: The hospital implemented improved testing methods hospitalwide to reduce duplicate testing on inpatients (rework) in the laboratory to get more reliable test results faster to help physicians plan a treatment course and eliminate avoidable days (waiting). It was also designed to gain the trust of the hospital’s medical staff, particularly with Clostridium difficile testing.

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Operational Excellence: Infrastructure

Project Title: Pilot Project to Improve Specimen Labeling and Accuracy

Hospital/System: St. John's Hospital, Springfield

Summary: The hospital was experiencing an occurrence rate of inaccurate or incomplete labeling of specimens. This trend was identified in quality indicator reports and internal audits performed by pathology. It delayed specimen processing and had the potential to affect the lab’s ability to process tissue specimens correctly. Not only was this a patient safety issue but had the potential to be a huge patient satisfaction issue if a repeat procedure was deemed necessary for further evaluation—from both a convenience and cost perspective.

This program also supports Just Culture principles as it calls attention to at-risk behaviors and coaches colleagues to perform a scripted, predictable process that has proven to lead to successful outcomes. It empowers colleagues to pause and stop if there are any questions or concerns about the name of the specimen and the test they’re being asked to perform. It facilitates a choice to participate in the Final Check/Say it Out Loud process. If any colleague chooses not to participate, corrective action would follow.

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Operational Excellence: Infrastructure

Project Title: Poor Pharmacy Inventory Management

Hospital/System: Kewanee Hospital, Kewanee

Summary: The new pharmacy director was faced with formulary inventory that was overgrown with under-utilized medications and clinically-duplicative compounds. There was insufficient attention being paid to the use of lower-cost therapeutic equivalents. The drug expenses over exceeded the revenue generated; thus, a management project was initiated by the director of quality, director of pharmacy and chief nursing officer, along with the use of Crimson. Crimson is a third-party tool, based on claims data, for physicians and administrators to analyze hospital data.

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Operational Excellence: Infrastructure

Project Title: Risk Management and Patient Safety: Informed Policies To Prevent Retained Foreign Objects

Hospital/System: University of Chicago Medical Center, Chicago

Summary: In July 2011, the academic medical center began an organizational quality and safety initiative focusing on a reduction in the occurrence of patient harm events. One of the identified initiatives was to reduce the occurrence of retained foreign objects (RFOs) by 25%, with a target goal to work towards zero. Aligning with this initiative, the Retained Foreign Object Task Force was developed, which included representation from various clinical, administrative and technological disciplines.

The RFO Task Force quality improvement initiatives included: defining intentional and unintentional retained foreign objects; review and revision of the existing policies on retained foreign object prevention; modification of existing counting processes and tools; and development and implementation of criteria that would trigger an intra-operative x-ray. Ongoing assessment and development of policies and processes guided by frontline staff and leadership resulted in an 82% reduction in RFOs meeting publicly reported criteria and a 73% reduction in RFOs meeting internal criteria.

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Operational Excellence: Infrastructure

Project Title: Standardizing the Patient Identification Process Throughout the Organization

Hospital/System: Katherine Shaw Bethea Hospital, Dixon

Summary: The hospital identified an increasing trend of identification events through their incident reporting system. There was a 1.5 times increase in the number of errors between second and third quarter 2012. The goal was to reduce the patient identification error rate. The clinic directors led this team with an interdisciplinary approach utilizing Lean methodology.

The project included six satellite clinics, two sites of specialty physician clinics (involving 58 providers) and the main hospital. Strategies for improvement included revising the policy, clarification of expectations, education, standardizing the patient identification process, and root cause analysis by using the “5 why's” tool for each error. The outcome was a 63% reduction in number of errors comparing last six months and $19,101 approximate reduction in lost revenue.

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Operational Excellence: Infrastructure

Project Title: STROKE*45: Rapid Diagnostic Protocol Speeds Life-Saving Emergency Intervention for Acute Stroke Patients

Hospital/System: Memorial Health System, Springfield

Summary: For every 15 minute reduction in door-to-tPA time, there is an associated 5% reduction in mortality. For best outcomes, accurate acute stroke diagnosis using five Joint Commission recommended tests (EKG, Brain CT, BMP, CBC, PT/INR) must occur within 45 minutes of arriving to the Emergency Department. A Lean Six Sigma team created STROKE*45 to improve the hospital’s Primary Stroke Center performance. The STROKE*45 process decreased average door-to-diagnostic-test-completion time by 65% (74 minutes off the baseline), allowing a decrease in door-to-tPA time for eligible patients by 40% (48 minutes). Use of the Lean Six Sigma Define, Measure, Analyze, Design, Validate (DMADV) model fostered dramatic clinical improvements that were sustained and continuously improved through Define, Measure, Analyze, Improve, Control (DMAIC) methods, allowing for a more robust system of care for regional patients presenting with this disabling, acute neurological emergency.

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Operational Excellence: Infrastructure

Project Title: System Approach to Patient Engagement and Organizational Safety

Hospital/System: Hospital Sisters Health System, Springfield

Summary: The health system partnered with Press Ganey over the past three years to centralize and standardize patient satisfaction tracking and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPs). Collective work on proven strategies, hourly/leader rounding, scripting, and post-discharge phone calls were adopted with required participation supported by leadership including monthly accountability as part of the regular operations meetings focusing on shared best practices. In 2012, HCAHPs goals were added to executive compensation and the health system uses the program to assist with patient safety and leadership focus on operations to improve both service and consistency. Substantial gains in performance have been made.

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Operational Excellence: Infrastructure

Project Title: Using Computer Discrete Event Simulation to Improve Operating Room Flow, Capacity Management and System Optimization in a 500-Bed, Academically-Affiliated, Tertiary, Level I Trauma Medical Center

Hospital/System: Memorial Health System, Springfield

Summary: Discrete event simulation (DES) modeling is an innovative approach for health care organizations to model and improve processes in a virtual computerized environment setting, thus, reducing the cost of real-world trial and error and avoiding disruptions of day-to-day operations while developing statistically valid re-engineering solutions to hospital flow and throughput. Using DES modeling facilitates optimization of complex patient care systems, as opposed to singular process improvements.

Computer DES modeling was used to analyze floor design and flow for all aspects of the architectural design proposal for a $31 million, two-story operating room (OR) expansion project. This included pre-op admission, transport to OR, OR time, and post-anesthesia care units (PACU) for admitted and outpatient surgery in a Level I Trauma Center/Tertiary Urban Operating Room. DES modeling techniques based on advanced dynamic queueing theory were used to determine the appropriate facilities layout for the new OR, which includes a 15% anticipated increase in volume over the next five years. Traffic flow was optimized through the addition of a third elevator, designed to result in a 30-minute reduction per case in wasted movement and waiting, potentially increasing OR capacity by up to 10 cases per day.

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Operational Excellence: Infrastructure

Project Title: Using Lean Six Sigma and Flexible Scheduling to Increase Rehabilitation Therapist Productivity

Hospital/System: Memorial Medical Center, Springfield

Summary: Using robust Lean Six Sigma methodologies, a flexible patient care assignment schedule administered by clerical support staff was designed to improve productivity of physical and occupational therapists serving an inpatient acute orthopedic unit. Therapist time spent scheduling patients was reduced from 1.5 hours per day to 0 hours per day. Productivity, defined by billed units of skilled therapy provided per day, increased by 19% for Physical Therapists and 9% for Occupational Therapists. The change from a rigid fixed therapist-controlled schedule to a flexible one managed by support staff enhanced operational efficiency with no negative impact on patient satisfaction, clinical progress or discharge planning.

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Operational Excellence: Infrastructure

Project Title: Using Lean Six Sigma to Decrease Diagnostic Turn-Around-Time and Protect Market Share in Outpatient Reference Lab Business

Hospital/System: Memorial Medical Center, Springfield

Summary: Market competitors offering faster anatomic pathology result turn-around-time (TAT) threatened the hospital’s multi-million dollar regional reference lab business. Delays in results reporting decrease referring physician confidence and delay patient-centered care. A Lean Six Sigma project focused on improving lab throughput efficiency through demand/capacity matching and staffing optimization. The Lean principle of smooth flow was a core concept in the intervention to level the demand load.

Results indicated a 39% improvement in turnaround time (2.69 to 1.65 days). An additional benefit was enhanced pathology physician productivity and satisfaction with enhanced lab processing. These interventions precluded loss of vital reference client business in the increasingly competitive marketplace, and enhanced patient care through faster diagnostic result reporting.

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Operational Excellence: Patient Throughput
Operational Excellence: Patient Throughput

Project Title: Early Intervention of ST Elevation Myocardial Infarction (STEMI) through Pre-Hospital ECGs to Reduce Door-to-PCI Time and Improve Patient Outcomes

Hospital/System: OSF HealthCare, Peoria

Summary: A systemwide opportunity was identified to improve the care of patients experiencing an ST elevation myocardial infarction (STEMI). The scope of the original project was to effectively reduce STEMI identification and treatment time, and included three system percutaneous coronary intervention (PCI) hospitals. As the STEMI project evolved, three non-PCI system hospitals were added to assure they participated in shortening the door-to-treatment time while routing the patient. This took extensive collaboration across a multidisciplinary team. Early diagnosis of STEMI reduces the overall door-to-PCI time by early activation of the Emergency Department, Cath Lab and air transport (when applicable), resulting in rapid intervention.

During the project, it became apparent that an opportunity existed to dramatically shorten the first patient contact to PCI time by allowing emergency medical services (EMS) to obtain and send an initial ECG to the nearest facility allowing for earlier activation of the STEMI system. Funding was provided to 48 EMS agencies and 14 affiliated and non-affiliated hospitals across Central and Northern Illinois to acquire the necessary software and hardware to transmit a pre-hospital ECG. For patients transported by several additional EMS agencies who technically could not apply the pre-hospital technology, the project team developed an education program to train the EMS agency staff in reading ECGs in the field.

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Operational Excellence: Patient Throughput

Project Title: Improving Patient Safety and Throughput at the ED Front Entrance

Hospital/System: UnityPoint Health - Methodist, Peoria

Summary: The flow around the Emergency Department’s (ED) check-in desk was congested with lots of cross-traffic from patients, doctors, nurses, techs, and registration staff. Most patients were checked-in by non-clinical staff and sent to a waiting area creating a patient safety issue. Arrival to Emergency Severity Index (ESI) assignment was more than 10 minutes per patient. Arrival to bed averaged more than 25 minutes, length of stay averaged 180 minutes and left without being seen (LWBS) was more than 2.5%.

Using Lean tools and methodologies, the staff and physicians were able to design a new check-in area that ensured all patients were checked in by a nurse. ESI assignment reduced four minutes per patient, arrival to bed time reduced by 54%, overall length of stay for all patients decreased by 15 minutes, LWBS decreased by 54%, and unusable space was recaptured to increase ED capacity.

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Operational Excellence: Patient Throughput

Project Title: Lean Six Sigma Reduction of Inpatient Average Length of Stay: Implementing an Anticipated Discharge Process

Hospital/System: Memorial Medical Center, Springfield

Summary: Reduction of excess inpatient days was an organizational improvement priority, with the focus of this Lean Six Sigma project on reducing average inpatient length of stay (ALOS) by 0.5 day through a hospitalist physician-directed anticipated discharge process. Among multiple causes of discharge delay identified, the following strategies were selected for improvement: 1) a redesigned value-stream process map for role and flow clarification; 2) new physician “Anticipated LOS” order process; 3) development of electronic “Progress to Discharge” checklist; and 4) scheduled patient discharge appointments.

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# Operational Excellence: Patient Throughput

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<td>Hospital/System:</td>
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<td>Summary:</td>
<td>Patient delays in discharge and avoidable patient days in the hospital are costly, inefficient and frustrating to patients. The team applied Lean techniques to improve patient flow from the time a patient enters the facility until they are discharged. The hospital had a multidisciplinary team, with representation from the entire hospital, to ensure the process changes improved patient flow as a system.</td>
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Operational Excellence: Patient Throughput

Project Title: Patient Flow Improvements in Outpatient Testing

Hospital/System: Silver Cross Hospital, New Lenox

Summary: Through observation and interviews, it was noted that staff was unaware when a patient was ready for testing. Patients waited for their test even when staff was available to assist them. Additional steps were required to navigate around patient rooms where privacy was an issue. Hospital staff applied Lean techniques to improve staff workflow. Several changes were added to modify workflow, add visual cues and improve patient privacy such as: installation of a remote control light in the staff workstation to visually cue staff when a patient checks in; modification of the swing direction of the door hinge to allow staff to visually see patients who are waiting, while still respecting patient privacy; laboratory staff traveling 80% shorter distance from workroom to the front desk; and moving registration kiosks to a location on the path of patients entering the department—helping patients to find registration, and preventing patients from having to backtrack to the waiting room after registration.

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Operational Excellence: Patient Throughput

Project Title: Patient Flow Management

Hospital/System: Sarah Bush Lincoln Health Center, Mattoon

Summary: In December 2011, the health center instituted a hospitalwide quality improvement initiative to improve overall patient throughput, patient experience of care and interdepartmental collaboration. The project focuses on daily evaluation of available inpatient beds, predicted discharges and potential admissions from all access points to: optimize patient flow; decrease Emergency Department (ED) boarding time; accommodate continually increasing volumes in the ED; and facilitate timely patient placement at the appropriate level of care.

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Operational Excellence: Patient Throughput

Project Title: Patient Flow Optimization

Hospital/System: Blessing Hospital, Quincy

Summary: The hospital utilized data to initiate changes in the Surgery Department, the Catheterization Lab and the Emergency Department (ED). Optimizing the surgeon blocks, establishing guidelines for urgent/emergent cases and using data to make decisions, were key components in improving surgery processes. The Catheterization Lab found moving to a structured scheduling process was the key to improvement for their patients while a Rapid Diagnostic Area was created in the ED to shorten patient length of stay.

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Operational Excellence: Patient Throughput

Project Title: Reducing Avoidable Chemotherapy Delays in a Hospital-Based Outpatient Infusion Unit

Hospital/System: Memorial Medical Center, Springfield

Summary: The hospital’s outpatient infusion unit volume increased by 54% over the last three years, causing delays for patients receiving treatments including chemotherapy. A Lean Six Sigma project was initiated to address patient and referring physician requirements that infusion begin within one hour of the patient's scheduled appointment time (expected start time).

Baseline data (Nov. 26, 2012 – Dec. 21, 2012) revealed significant variation in start times (standard deviation = 53 minutes) indicating frequent predictable failures to meet customer requirements. Intervention focused on information required at time of patient arrival for safe, timely chemotherapy delivery. Post-intervention data collection (April 2, 2013 - April 29, 2013) showed that average chemotherapy treatment start times improved by 15%, or 12 minutes, and standard deviation decreased by 11 minutes.

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Operational Excellence: Patient Throughput

Project Title: Reducing Emergency Department Non-Admit Length of Stay Using Rapid Clinical Examination (RCE)

Hospital/System: Memorial Health System, Springfield

Summary: In recent years, the hospital’s Emergency Department/Level I Trauma Center volume has grown to provide 70,000 visits per year servicing nearly 60% of the market share. With this growth comes increased length of stays for non-admitted (treat and release) patients, reducing customer satisfaction. Using a Lean Six Sigma method, a new delivery model known as Rapid Clinical Examination (RCE) was implemented to better address the needs of this population.

Results showed a 35% decrease in the number of patients leaving without treatment and a 17% decrease in length of stay. Overall, RCE improved these important metrics by providing more reliable performance across daily and hourly volume variations, yielding a smoother patient flow that resulted in better care delivery and higher patient satisfaction. In fact, for the first four months of 2013, the Emergency Department scored in the top decile of Press Ganey national patient satisfaction scores.

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Operational Excellence: Patient Throughput

Project Title: Reducing Patient Wait Time for an Inpatient Bed through Improved Patient Flow

Hospital/System: Presence Covenant Medical Center, Urbana

Summary: The goal was to reduce wait time between request for a bed to head-in-bed by 25%. The vice president of Patient Care Services and the director of Process Improvement led the project using Lean methodology. Strategies to achieve improved patient flow included optimization of bed management processes, cleaning and transport staffing, and multidisciplinary rounds. Outcomes included a 50% improvement in request for a bed to head-in-bed time.

As a result, mean Emergency Department (ED) arrival to ED departure times decreased by 47 minutes. Additionally, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) overall score on the multidisciplinary rounds unit improved 14% versus a 4% improvement on the other units.

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Operational Excellence: Patient Throughput

Project Title: ROMI - Rule Out Myocardial Infarction

Hospital/System: Richland Memorial Hospital, Olney

Summary: The outcome of ST elevated myocardial infarction (STEMI) events depends greatly on the care patients receive and the time frame in which they receive it. The hospital’s Emergency Department (ED) has successfully implemented a Rule Out Myocardial Infarction (ROMI) program as part of its quality improvement initiatives. The ROMI project goal is to reduce the average time to EKG for patients presenting to the ED to less than five minutes and to receive the Troponin result in under 60 minutes.

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Operational Excellence: Patient Throughput

Project Title: Using Computer Discrete Event Simulation to Improve Emergency Department Patient Flow, Capacity Management and System Optimization in a 500-Bed, Academically-Affiliated, Tertiary, Level I Trauma Medical Center

Hospital/System: Memorial Medical Center, Springfield

Summary: Computer discrete event simulation (DES) modeling was used during Q2 FY2013 to deploy an innovative best practice Rapid Clinical Examination model to improve throughput and service delivery in a Level I Trauma Center/Tertiary Urban Emergency Department (70,000 visits per year). Using discrete event simulation modeling facilitates optimization of complex patient care systems, as opposed to singular process improvements. DES modeling based on advanced dynamic queueing theory principles to optimize staffing and system design resulted in: a 26% reduction non-admitted patient length of stay (209 to 155 minutes); 55% decrease in percentage of patients leaving without treatment (LWOT: 2.5% to 1.27%); 74% reduction in admit bed hold time for admitted patients (350 to 91 minutes); and Press Ganey patient satisfaction scores that increased from the 57th to 99th national percentile.

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Operational Excellence: Team-Based Leadership
Operational Excellence: Team-Based Leadership

Project Title: Hand-Off Communication: Shift-to-Shift Report

Hospital/System: RML Specialty Hospital, Hinsdale

Summary: This was a Lean Six Sigma project chartered to improve a lengthy and inconsistent report process that dissatisfied staff and management. A multidisciplinary team representing RNs, patient care technicians (PCTs) and respiratory care practitioners (RCPs) from all shifts and both sites of the organization worked to review data, identify issues and their sources, and brainstorm solutions.

The team developed a standardized report process for each discipline that met their individual discipline's needs and stayed within project boundaries. Ground rules were also established to serve as a set of behavioral expectations and were adopted across all disciplines. Staff is being held accountable to this new way of communicating and handing off patients through direct observations, periodic auditing and annual performance reviews.

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Patient Safety and Quality
Patient Safety and Quality

Project Title: Adopting a Latex-Safe Environment: Enhancing Safety for Patients and Staff by Reducing Exposure to Latex Gloves and Products

Hospital/System: Memorial Health System, Springfield

Summary: In 2010, latex gloves were removed from use by employed patient care staff though maintained as a physician preference item. In 2012, prompted by a near-miss patient exposure event, the issue was re-evaluated using Lean Six Sigma methods including Failure Modes and Effects Analysis (FMEA). Analysis revealed rampant use of latex gloves across the health system at a rate of approximately 4,000 pairs per month, indicating the failure of the previous “improvement” effort.

Charged by the Quality and Safety Performance Committee's physician members to engage a process to remove latex glove products, management successfully worked with more than 100 physicians to identify, sample and endorse acceptable latex-free glove alternatives from several vendors. All remaining latex glove products were located and removed across the health system and new central supply stocks were developed.

The organization has been 100% latex-glove free since March 2012. With the assistance of the Materials Management Team, ongoing monitoring occurs to assure that latex gloves are not being ordered anywhere within the health system, and the Quality Audit Team performs regular audits in all clinical areas to monitor for the presence of any latex gloves. In addition to this conversion, an additional 15 latex products have been replaced with latex-free alternatives.

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Patient Safety and Quality

Project Title: Implementing a Transfusion Safety Initiative Across an Integrated Health System

Hospital/System: Advocate Health Care, Downers Grove

Summary: Beginning in 2011, the health care system committed to improving transfusion practice by focusing on the patient safety implications of the medical decision to transfuse blood products. Accompanying this decision were the challenges of impacting the care of more than 27,000 patients that receive blood products annually, and reaching 1,500 physicians and 5,000 nurses. The system focused on leveraging the expertise and leadership of front line clinicians including medical staff leaders in surgery, oncology, hematology, pediatrics, neonatology, and transfusion medicine, who developed consensus guidelines on the indications for blood product transfusion for adult and pediatric patients.

By utilizing education, Computerized Physician Order Entry and multiple system projects to support the guidelines, the system's patients realized a 29% decrease in Red Blood Cell utilization at the level I trauma sites and 31% decrease at the non-trauma sites. This decrease resulted in avoiding 470 complications, saved 17,580 inpatient days, saved 105 lives, and created a $5.6 million dollar savings in the cost of delivering care associated with blood transfusion.

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Patient Safety and Quality: Culture
Patient Safety and Quality: Culture

Project Title: A Multi-Strategy Approach to Improving Patient Safety through Reducing the Use of Restrictive Interventions

Hospital/System: Hartgrove Behavioral Health System, Chicago

Summary: The hospital's project was to reduce the unintended consequences that restrictive interventions may have on patients. Patient and provider engagement has allowed the hospital to learn from those who know the patient best and build treatment and intervention techniques around the patient. This results in better management of behaviors that place the patient and others at greater risk. Improvements made to the milieu and the structure of high-risk events have lead to a decrease in the need for restrictive interventions.

Using successive year comparisons, 2011 - 2012, the hospital has been able to demonstrate a 67% reduction in the rate of seclusions, a decrease in physical restrain rate by 51%, a decrease in mechanical restraint rate by 42%, and a decrease in intramuscular stat medication rate by 33%. Staff education and changing the culture around the use of restrictive interventions has lead to improving the staff's professional skill set in predicting behaviors that typically have lead to the use of restrictive interventions. Staff and patients have learned the culture of maintaining safe environments and promoting internal control when emotional arousal occurs. Patient safety has improved as a result of these systemic changes.

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Patient Safety and Quality: Culture

Project Title: Changing our Culture: A Journey to Excellence

Hospital/System: Adventist Hinsdale Hospital, Hinsdale

Summary: This quality improvement project was to change the culture of the 2 Medical inpatient unit in order to improve patient and staff satisfaction. A new manager was hired in March 2011 with the task of increasing unit patient satisfaction scores which were at the 7th percentile, while staff satisfaction was at the 9th percentile. Additionally, these scores are available to the public through publically reported data and the organization's pursuit of Magnet status. Challenges for this 61-bed, 90+ staff member unit included: high management turnover, inconsistency, lax enforcement of rules, lack of accountability, poor conflict resolution, and a culture of negativity.

Ideally, the best approach would have been to take time and build relationships with staff before coming in and making drastic changes. However, time was an issue and the manager created an action plan with a timeline and submitted it to Administration. If asked to attribute the improvement to any one action plan item it would be near impossible—it was hundreds of little changes that helped shape and improve the culture.

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Patient Safety and Quality: Culture

Project Title: Patient Safety Liaisons: Empowering Frontline Staff to Measurably Improve Patient Safety and Quality with Advanced Safety Training, Protected Time and Quality Process Improvement Training

Hospital/System: Cadence Health, Winfield

Summary: The mission of the patient safety liaison (PSL) group is: enhancing patient and staff safety through simplifying processes; identifying opportunities for provision of safer care; working to proactively eliminate safety threats; ensuring robust, protected reporting of safety concerns; and providing frontline and safety science expertise to patient care improvement teams throughout the hospital. Changes were achieved through use of the Institute for Healthcare Improvement model for improvement with the notable addition of unit-based champions, an evidence-based intervention.

Utilizing frontline staff to design, implement, role model, and champion practice change, resulted in practical improvements and increased buy-in. By providing frontline staff with protected time and advanced training in safety science and quality improvement, the PSL program has improved critical lab reporting, spread a culture of safety and reporting, improved medication safety at discharge, improved compliance with cleaning IV access ports, and increased participation in safety checks at handoff, in addition to implementing department or unit-based improvements throughout the system.

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Patient Safety and Quality: Culture

Project Title: Restrictive Measures Initiative

Hospital/System: Streamwood Behavioral Healthcare System

Summary: The organization implemented a project task force to reduce the number of restrictive measures. They developed a Performance Improvement Team (PIT) to address changing the hospital culture from a punitive environment to a therapeutic environment. This would help to reduce the number of restrictive measures. The PIT consisted of the chief medical officer, chief nursing officer, director of clinical services, director of risk/performance improvement, nurse and clinical managers, and frontline staff. The PIT met on a weekly basis for one year (1st Quarter 2012 - 1st Quarter 2013) developing a strategy to reduce the organization’s restrictive measures.

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Patient Safety and Quality: Infections
Patient Safety and Quality: Infections

Project Title: High-Absorbency Pad Trial

Hospital/System: Kindred Hospital Sycamore, Sycamore

Summary: Any patient who is incontinent that does not require a foley as a medical necessity, will have a disposable, high-absorbency pad to reduce skin breakdown and the use of briefs and foley catheters.

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Patient Safety and Quality: Infections C. diff
Patient Safety and Quality: Infections C. diff

Project Title: Collaborative Approach to Reduce Hospital-Acquired Clostridium difficile in Conjunction with Terminal Patient Room Cleaning and the Use of Ultra Violet (UV) Light

Hospital/System: Ingalls Memorial Hospital, Harvey

Summary: The goal was to reduce Clostridium difficile (C. diff) transmission from inpatient to inpatient room occupancy as well as reduce readmissions. The hospital convened a multidisciplinary team to examine, research and develop protocols. This joint effort involved Infection Control, Laboratory, Environmental Services, Physicians, Nursing, Pharmacy, and Information Technology Systems. The hospital became the first one in the area to use the RD Rapid UV Disinfector, an innovative technology that utilizes UV light to kill C. diff in patient rooms after terminal room cleaning.

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Patient Safety and Quality: Infections C. diff

Project Title: Improvement in Early Identification and Diagnosis of Clostridium difficile

Hospital/System: Adventist Bolingbrook Hospital, Bolingbrook

Summary: Developed in July 2012, the Clostridium difficile Infection (CDI) collaborative is an ongoing initiative to improve the early identification and treatment of CDI patients during acute inpatient hospitalization. The collaborative features a multidisciplinary team with a Clinical Coordinator as the collaborative champion including representation from front line nurses, clinical coordinators, patient care technicians, therapists, nursing leadership, pharmacy, environmental services, nursing education, case management, and infection prevention.

One team goal was to develop early identification of community onset CDI. The following processes were already in existence: specimen testing by Nucleic Acid Amplified Test method (NAAT); contact precautions from the initial order for C. difficile test, (if positive, CDI precautions remained in effect until discharge); every room of a positive CDI patient's room cleaned with bleach at discharge; environmental services monitoring the efficiency of cleaning discharged rooms with a black light; and pharmacy with a seven-day auto stop on antibiotics. The team meets every two months to evaluate CDI data and to discuss how to decrease health care-associated CDI.

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Patient Safety and Quality: Infections C. diff

Project Title: Reducing Health Care-Acquired Clostridium difficile - A System’s Approach

Hospital/System: St. Mary’s Hospital, Centralia

Summary: As of part of the Premier Quest Collaborative, safety reports, including harm or hospital-acquired condition measures, were sent to each hospital. Since each campus was in the red on the scorecard for hospital-acquired C. difficile, a Continuous Quality Improvement plus Team was sanctioned to reduce hospital-acquired C. difficile. The number of C. difficile cases for the two hospitals was reduced five fold, from a high of 11 cases per month to an average of 2.2 cases per month. This was accomplished even with changing from Toxin A/B EIA testing to the highly sensitive PCR testing.

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**Patient Safety and Quality: Infections C. diff**

**Project Title:** Reduction in Health Care-Associated Clostridium difficile in a Rural Hospital Using a Collaborative Interdisciplinary Approach

**Hospital/System:** FHN Memorial Hospital, Freeport

**Summary:** The hospital’s objective was to reduce the number of health care-associated C. difficile (C. diff) infections below the national averages of 13 per 10,000 patient days using best practice guidelines, current literature and internal data. Literature documents that the two major reservoirs of C. diff in health care settings are infected humans and inanimate objects. Following national infection prevention guidelines alone, such as hand washing with soap and water, to guide efforts to reduce C. diff infections proved to be insufficient.

Through teamwork and cooperation amongst our Physicians, Staff Nurses, Infection Preventionist, and Environmental Services staff, their revised strategy included: eliminating unnecessary antibiotics; daily patient surveillance to identify patients at risk for developing C.diff infections (inclusive of patients admitted with diarrhea and those taking an antibiotic in combination with a proton pump inhibitor); ordering probiotics when applicable; and standardizing the cleaning of patient rooms. Integrating this collaborative and proactive approach yielded a 75% reduction in C. diff infections from baseline.

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Patient Safety and Quality: Infections C. diff

Project Title: Stool Transplants: A Treatment for Recurrent Clostridium difficile

Hospital/System: Memorial Hospital, Belleville

Summary: There is an increase in the national rate of patients experiencing recurrent Clostridium difficile (C. difficile) unresponsive to standard antimicrobial treatment. Stool transplants are a safe and effective treatment in the eradication of C. difficile. C. difficile relapses have been reported in up to 20% of patients. This alternative treatment involves transplanting or infusing stool from a healthy donor into the gastrointestinal tract of a C. difficile patient. An 89% success rate to cure C. difficile has been achieved since the implementation of the stool transplant program.

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### Patient Safety and Quality: Infections C. diff

**Project Title:** Transforming Care of Patients with Clostridium difficile through Enteric Flora Transfer

**Hospital/System:** Memorial Medical Center, Springfield

**Summary:** Enteric flora transfer (EFT) is an emerging powerful treatment for patients with severe recurrent Clostridium difficile (C. difficile) infections of the bowel. Enteric flora are transplanted using healthy donor patient fecal sample according to strict protocol to recolonize the infected bowel with healthy bacteria to provide resolution of debilitating C. difficile symptoms, reduce patient suffering and system cost. Treatment objective was defined as patient remaining symptom-free for a two-week period following EFT infusion.

In an initial series of 21 patients, an overall success rate of 90.5% was achieved. Sixty-two percent were symptom-free after only one infusion, while 38% required a repeat infusion to achieve success. These rates of remission far exceed those achieved through traditional treatments, and prevented colon resection/removal surgery in the majority of these patients.

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Patient Safety and Quality: Infections CAUTI
**Patient Safety and Quality: Infections CAUTI**

**Project Title:** A Multidisciplinary Approach to CAUTI Reduction

**Hospital/System:** Ingalls Memorial Hospital, Harvey

**Summary:** The hospital developed a multidisciplinary team approach to reduce the incidence of CAUTI. The CAUTI Team consists of representatives from medicine and nursing, with a physician designated champion and each unit having a designated care-associated champion. The multifaceted approach included development of appropriate, evidence-based criteria for catheter use, careful surveillance, physician and nurse education, standing orders for discontinuation, and accountability measures.

The hospital’s catheter days dropped from 15,364 in 2011 to 9,678 in 2012, while CAUTI incidence dropped from 15 in 2011 to 5 in 2012. Additionally, the hospital is part of a statewide CAUTI initiative. The cohort within which the hospital resides has seen a decrease in CAUTI rate per patient day from 6.8 at baseline, to 4.11 after implementation, to a sustainability rate of 1.3.

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Patient Safety and Quality: Infections CAUTI

Project Title: Achieve Top 10th Percentile Compliance with National Hospital Quality Measure/Core Measure SCIP Infection 9

Hospital/System: SwedishAmerican Hospital, Rockford

Summary: This community hospital and medical staff were experiencing considerable frustration in not meeting the Joint Commission and Centers for Medicare & Medicaid Services’ Surgical Care Improvement Project (SCIP) goal of removing the urinary catheter by post-operative day one or two. It was recognized by the hospital’s Board who reviewed results quarterly, by leadership, caregivers, and the Quality Resource department. Not only was this considered unacceptable performance for Core Measures compliance, but literary evidence strongly points to the removal of indwelling urinary catheters to prevent urinary tract infections in patients.

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**Patient Safety and Quality: Infections CAUTI**

**Project Title:** Decrease the Number of Catheter-Associated Urinary Tract Infections (CAUTIs) by 50% by June 30, 2012

**Hospital/System:** Cadence Health, Winfield

**Summary:** Urinary Tract Infections (UTIs) account for approximately 40% of all health care-associated infections annually. Indwelling urinary catheters are responsible for 80% of these hospital acquired UTIs. During one quarter, the total number of hospital CAUTIs was 13.

The goal was to decrease CAUTIs by implementing four recommended components of care: 1) Avoiding unnecessary urinary catheters; 2) Inserting urinary catheters using aseptic techniques; 3) Maintaining urinary catheters based on recommended guidelines; and 4) Reviewing catheters daily and remove promptly.

The project scope included adult patients with indwelling urinary catheters in critical care, med/surg units, Emergency Department, Operating Room, Interventional Labs, Labor and Delivery, and Mother Baby. The team focused on process boundaries of catheter insertion, catheter maintenance and catheter removal. The project began with a pilot in adult critical care and then was implemented housewide.

Interventions included a multi-pronged approach that involved staff education, product review, concurrent review of patients with catheters, housewide campaigns (e.g. “Date Me And Take Me Out”), and the implementation of a nurse-driven indwelling urinary catheter protocol.

These efforts resulted in the reduction of CAUTIs by 86%.

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Patient Safety and Quality: Infections CAUTI

Project Title: The Successful Journey of an Interdisciplinary CAUTI Team as a Model Template for Other Quality Improvement Applications

Hospital/System: Presence Saint Joseph Hospital, Elgin, Elgin

Summary: A Catheter-Associated Urinary Tract Infection (CAUTI) project charter was developed for the pilot. The team is comprised of nursing administration, education, clinicians, infection control, quality, and central processing. Data is collected on the incidence of indwelling catheters using a daily electronic report. The need for the indwelling catheter is assessed during daily discharge patient rounds in addition to nurse-to-physician and nurse-to-nurse hand-off communication. CAUTIs are reported monthly by infection control and reviewed during unit meetings. The educational plan consists of a computer-based learning module and hands-on training with mobile learning stations. Nurses, assistants, transporters, and therapists participated in appropriate competencies.

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Patient Safety and Quality: Infections CLABSI
Patient Safety and Quality: Infections CLABSI

Project Title: A Hospitalwide Journey to Reduce CLABSI: Implementation of Alcohol Disinfection Caps and CHG Bathing in the Cardio/Neuro Intensive Care Unit

Hospital/System: Edward Hospital, Naperville

Summary: Reducing CLABSI hospitalwide has been a continuous work in progress. Implementing central line bundles, engaging senior leadership and data transparency has helped the hospital move along in this journey. While the hospital’s original mission was to “beat the benchmark,” its goal has advanced to “get to zero and stay at zero.” Reducing CLABSI infections requires attention to detail not only in line insertion, but also in line maintenance and product selection/utilization.

In January 2012, after reviewing a root cause analysis on a CLABSI case, the cardiac/neuro intensive care unit (CNICU) decided to participate in an alcohol disinfection cap pilot. Realizing that placing these caps on all lines would benefit all patients, the caps were eventually rolled out hospitalwide. Following implementation, CLABSI data showed improvement, but the hospital wanted to do more.

In April 2012, CNICU implemented Chlorhexidine Gluconate (CHG) basin baths. Thorough education was provided and later this too was implemented hospitalwide. On January 11, 2013, CNICU hit their one-year milestone without a CLABSI and, to date, they are 532 days CLABSI free.

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Patient Safety and Quality: Infections CLABSI

Project Title: Caring for Central Venous Catheters: Striving for Zero Central Line-Associated Blood Stream Infections (CLABSIs) on a Periatric Hematology/Oncology/Stem Cell Transplant (Hem/Onc/SCT) Inpatient Unit

Hospital/System: Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago

Summary: The purpose of this project was to reduce CLABSIs in pediatric Hem/Onc/SCT patients with central venous catheters (CVCs). This was a national study allowing children's hospitals to work collaboratively on eliminating CLABSIs in this patient population through implementation of best practices for maintenance of CVCs. Although the reduction of CLABSIs is not a unique problem in hospitals today, there are unique challenges in the Hem/Onc/SCT population that need further evaluation.

The main goals of this project were to reduce CLABSIs in pediatric Hem/Onc/SCT by 50%, comply with the CVC maintenance practices (goal=90%) and improve teamwork for all medical staff. The hospital's inpatient Hem/Onc/SCT unit started tracking CLABSIs in December 2009. At the end of 2010, its CLABSI rate was 2.71/1000 line days which reflected room for improvement. Due to an estimated 10-20% mortality/morbidity and high costs associated with CLABSIs, a national collaborative was necessary. The hospital enrolled in the project/study in April 2011.

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Patient Safety and Quality: Infections CLABSI

Project Title: Innovative Technique and Assurance of Clinical Competency to Successfully Reduce Central Line-Associated Blood Stream Infections (CLABSI)

Hospital/System: University of Chicago Medical Center, Chicago

Summary: Quality improvement initiatives included: creation of a pre-packaged Central Line (CL) Insertion Kit with supplies layered in the order of appropriate use to guide compliance with institutional protocol; creation of an institution-specific process for accessing and maintaining central lines including enforcement of routine days for dressing changes and a “scrub-flush-scrub-medicine-scrub-flush” protocol; implementation of 1:1 validation and teach-back of appropriate technique for every nurse across the medical center including adult, pediatric, support nursing staff, and home health nurses; mandatory computer-based training with institution-specific videos (showing proper procedure and pre-packaged Central Line Insertion Kit use) and testing requiring 92% accuracy to meet annual competency requirements; and quality review of all CLABSI cases in order to assess gaps in policy, compliance and training.

Rates of CLABSI have been dramatically reduced, exceeding the institutional goal of 0.8 CLABSI/1,000 CL-days and reaching a sustained 0.6 CLABSI/1,000 CL-days.

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Patient Safety and Quality: Infections Pneumonia
Patient Safety and Quality: Infections Pneumonia

Project Title: Development of an Intervention for the Prevention of Aspiration Pneumonia in Critical Care Patients

Hospital/System: Elmhurst Memorial Hospital, Elmhurst

Summary: Aspiration pneumonia represents a significant proportion of all pneumonia cases. It affects older hospitalized adult patients who have one or more major aspiration risk factors. A quality improvement project was designed to evaluate pre- and post-implementation outcomes following an evidence-based aspiration risk assessment and protocol. The protocol included early swallow evaluation by RN and referral to speech therapy.

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Patient Safety and Quality: Infections Surgical Site Infections
Patient Safety and Quality: Infections Surgical Site Infections

Project Title: A Pre-Operative Approach to Reducing Surgical Site Infections (SSI)

Hospital/System: Rockford Health System, Rockford

Summary: In January 2011, the organization incorporated three Infection Prevention (IP) clinical indicators to the System Quality Scorecard: catheter-associated urinary tract infection (CAUTI), central line-associated blood stream infection (CLABSI), and six targeted surgical procedures to track SSIs. The rationale for the targeted procedures selection was based on: high-risk patient population with the potential for serious adverse outcomes, high-risk and/or high-volume procedures, publicly reported procedures, and the most common types of procedures (CABG, Total Joints). The six targeted procedures were: CABG, KPRO, HPRO, CARD, LAM, and FUSN. The 2011 scorecard goal: 25% reduction of 2010 Total SSI Targeted Procedures (2010 Actual: seven SSI/1225 procedures =0.57 Incidence rate). In March 2011, a post-CABG Mediastinitis case occurred in a high-risk patient with multiple comorbidities. The case was evaluated by application of “learning from defects” methodology.

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Patient Safety and Quality: Infections Surgical Site Infections

Project Title: Enhancing Surgical Safety: Reducing Infection Risk through Minimization of Immediate Use (Flash) Sterilization

Hospital/System: Memorial Medical Center, Springfield

Summary: Reducing surgical site infections is a key element in national efforts to reduce patient harm. One root cause of such infections is inadequate sterilization of instruments, with experts pointing to immediate use or flash sterilization methods as a particular area for action. A Lean Six Sigma team was charged with reduction of flash sterilization by optimizing the sterile processing areas of the organization. Improvement interventions including right-sizing inventory of surgical instruments, Lean processing instrument trays, standardized protocol with evidence-based indications for immediate use/flash sterilization, and benchmark targeted outcomes.

Results indicated a 92% reduction (from 12% to one percent of surgical instruments) in use of flash sterilization. An additional benefit of the project was improved OR efficiency due to pre-planning and avoidance of waits/delays associated with on-demand immediate sterilization.

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Patient Safety and Quality: Infections Surgical Site Infections

Project Title: Improving Surgical Safety Using Lean Visual Control System Technique: The Universal Protocol Stop (UPStop) Process

Hospital/System: Memorial Medical Center, Springfield

Summary: Risk of wrong site/side/procedure surgery increases dramatically when vital information is absent or changed on the date of surgery. To reduce this significant patient safety risk, a Lean Six Sigma team was prioritized to improve and standardize the pre-admission process to flag patients for whom last-minute changes require urgent communication and adjustments to electronic systems and/or equipment availability.

Using Lean principles of value stream mapping, “stop the line” culture, checklists, staff behavioral scripting, and visual control systems, intervention resulted in development of novel UPStop Protocol in which a large visual secondary wristband is affixed to patients flagged for specialized handling. This wristband, and associated actions, ensure that clinical and physician staff are on high alert regarding the last-minute changes, and engage scripted steps to ensure protection of patient from accidental patient harm. Since April 2013, UPStop has allowed zero incidents of "near miss" communication in transition from pre-admission to the OR

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Patient Safety and Quality: Infections Surgical Site Infections

Project Title: Surgical Site Infection Bundle Quality Improvement Initiative

Hospital/System: Northwest Community Hospital, Arlington Heights

Summary: American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) benchmarking data indicates that the hospital has been a high outlier for Surgical Site Infections (SSI). This project implemented Plan-Do-Study-Act (PDSA) cycles to improve SSI rates for eight subspecialties of surgery (General, Gynecology, Neurosurgery, Otolaryngology, Thoracic, Urology, and Vascular Surgery). The quality improvement project abstracted and analyzed data by hospital and ACS NSQIP; acted on the data; and monitored the interventions with data. The short-term goal was to decrease all SSI rates by at least 0.25% by March 2013. The long-term goal was to decrease all SSI rates by 0.5% by September 2013.

The interventions originated from a literature review and were primarily extracted from “Chasing Zero, The Drive to Eliminate Surgical Site Infections.” The interventions implemented were based off of access to immediate, tangible resources that would improve the SSI rates. The hospital met the majority of the short term goal except for decreasing the Deep SSI rate. Data to measure the long term goal was not available at the time of this application.

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Patient Safety and Quality: Infections Surgical Site Infections

Project Title: Total Hip Replacement Procedures: Reducing SSIs through a Multidisciplinary Approach

Hospital/System: Kishwaukee Hospital, DeKalb

Summary: The Joint Replacement Center of Excellence was established Jan. 1, 2011, with the goal of developing a destination center for hip and knee replacement. The organizational goal focused on creating a safe, patient-centered, outcome-focused environment for patients and staff.

In August 2012 when a spike in surgical site infection (SSI) rates of total hip replacement surgeries was observed, a multidisciplinary team was formed to conduct a gap analysis and identify root causes. Strategies for change included physician alignment with evidence-based infection control processes instituted throughout high risk procedure areas. Senior leadership provided needed resources to both implement and sustain a rapid-improvement process. With continued data analysis and multidisciplinary team support, this quality measure has been significantly reduced and is at a rate of zero to date.

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Patient Safety and Quality: Infections Ventilator-Associated Pneumonia
**Patient Safety and Quality: Infections Ventilator-Associated Pneumonia**

**Project Title:** Decrease Ventilator-Associated Pneumonia (VAP) Rate by Implementing the Interventions Identified from a Multidisciplinary Team Committed to the Goal of Zero VAP

**Hospital/System:** Blessing Hospital, Quincy

**Summary:** A multidisciplinary team including medical staff, pharmacists, clinical nurse specialist, respiratory therapy, nursing leadership and staff, and infection control developed an action plan to reduce VAP. The plan included: oral hygiene with Chlorhexidine Gluconate (CHG) for all ventilator patients; computer-based learning (CBL) education for nursing and respiratory therapy; increased monitoring of compliance of hand hygiene and isolation; introduction and implementation of subglottic suction endotracheal (ET) tube; a focus on decreasing ventilator days per patient; coordination of weaning assessment with sedation vacation; and implementation of an intensivist program.

Results showed zero identified cases of VAP. The greatest impact was the auditing of compliance and feedback provided to staff by leadership.

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Patient Safety and Quality: Injuries from Falls and Immobility
Patient Safety and Quality: Injuries from Falls and Immobility

Project Title: “No One Falls” is Achievable: Patient Fall Reduction in a Critical Access Hospital

Hospital/System: Advocate Eureka Hospital, Eureka

Summary: In 2009, inpatient falls at the facility peaked. A fall prevention team was assembled. In 2010, the number of falls decreased by 50%. Post-fall huddles were initiated in late 2010, which greatly enhanced insight into the reasons patients fell. However in 2011, the number of falls increased and the need for a more sustainable change in culture, beyond a simple quality improvement “project” was identified. Corporate-sponsored fall prevention initiatives, such as prevention measure triggers based on fall score, campaigns to increase staff awareness of increased fall risk and a fall calendar on the Intranet, complemented and supported site-specific efforts to decrease fall rate and improve patient safety.

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Patient Safety and Quality: Injuries from Falls and Immobility

Project Title: Keep Your Feet on the Ground Fall Prevention Program

Hospital/System: Presence Holy Family Medical Center, Des Plaines

Summary: Within the medical center’s substance abuse unit, many challenges revolved around the effectiveness of their fall prevention program. The fall rate climbed to a high of 5.91, the highest in their health care system. In 2012, the medical center joined the Hospital Engagement Network and took this opportunity to adopt a best practice approach. Staff attended two conferences with the goal of learning how to reduce their fall rate by 40%. The conferences enabled staff to engage with other hospitals and compare fall program best practices.

Following the conferences, a nurse became the fall prevention champion and is now a team leader for the Falls Task Force. The champion conducts ongoing educational sessions with both patients and staff. The Falls Task Force members include the unit manager, medical director, nurses, and patient care technicians and develops tools, material and processes for their Fall Prevention Program.

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Patient Safety and Quality: Injuries from Falls and Immobility

Project Title: Let’s Get Moving: How Maintaining Functional Mobility Impacts a Decrease in Patient Falls and Wound Prevalence and Increases Patient Satisfaction

Hospital/System: Presence Saint Joseph Medical Center, Joliet

Summary: The project implemented interventions to maintain patient functional mobility to avoid de-conditioning that occurs during inpatient hospitalization including, but not limited to, hospital-acquired wounds, while maintaining fall prevention best practices. The team utilized the Comprehensive Unit-Based Safety Program (CUSP) methodology to engage frontline staff and physicians in identifying safety hazards. The team sought to implement a “continue as home” philosophy, including a new functional screen prompting caregivers to assess the patient’s at-home activity level, as well as creating appropriate alerts to expedite physical therapy consults. Other tools included a new telemetry removal algorithm to facilitate patient showering, an updated safety plan to reflect patient activity and assistance needs, and improved bedside shift reporting.

The result showed a reduction in fall and wound prevalence levels to meet the unit’s goals and a significant increase in patient satisfaction rates. Qualitatively, the new protocol was found to decrease the debilitating effects of hospitalization.

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Patient Safety and Quality: Injuries from Falls and Immobility

Project Title: Prevention of Unassisted Falls in the Acute Care Hospital - Implementation of Best Practice Interventions and Culture Change Reduces Unassisted Falls by 70%

Hospital/System: Advocate BroMenn Medical Center, Normal

Summary: In 2011 and early 2012, the hospital’s fall rates were well above national averages in December 2011. A Fall Prevention Committee, including bedside staff, was established in January 2012 and a best practice bundle was developed to improve processes and change organizational culture.

As a result, from December 2011 to January 2013, the six-month rolling unassisted fall rate dropped by 70% and fall related injuries dropped by 58%. The best practice bundle included: Morse risk assessment with scoring thresholds to trigger use of bed alarms; “Fall Tool Stations” including kits with supplies for at risk patients; a “Safety Trumps Privacy” campaign to assure close monitoring of patients during toileting; an “All Hands on Deck” campaign to train non-nursing staff to recognize hazards and intervene to prevent a fall; and post-fall huddles to engage bedside staff in cause analysis.

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Patient Safety and Quality: Measurement and Reporting
Patient Safety and Quality: Measurement and Reporting

Project Title: Chasing 100: Providing the Right Care, at the Right Time. An Organization’s Implementation of Quality Surveillance Software and Monitoring Personnel to Meet the Core Measure Needs of Its Patients

Hospital/System: Kishwaukee Hospital, DeKalb

Summary: This project provided the hospital with a health systems approach to improve utilization of evidence-based quality measures to meet patients’ needs. This approach, which included implementing a computerized quality surveillance/reporting software system, along with changing the overall care delivery across the organization, incorporated evidence-based practice, quality surveillance and job responsibilities changes.

Results revealed a consistent improvement in patient outcomes with the goal of achieving and sustaining 100% compliance with Core Measure indicators. The health system had one hospital reach and sustain 100% compliance for all Core Measure indicators for the past two quarters; increasing from 90% since first quarter 2009. Another hospital is not far behind at 97% and 99% for the past two quarters, increasing from 89% since first quarter 2009.

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Patient Safety and Quality: Measurement and Reporting

Project Title:  SCIP Process Improvement

Hospital/System:  Silver Cross Hospital, New Lenox

Summary:  This project was intended to improve the hospital’s performance on the surgical care improvement project (SCIP) composite and reduce the rate of errors in that population. The project had two phases. The first phase was the introduction of Care Focus software which improved composite scores from 96.8 to 98.5. The second phase was to incorporate Care Focus with Surgery Live. This phase moved the composite further still to 99.5. The scope of this project includes all surgical patients included in SCIP.

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Patient Safety and Quality: Medication Management

Project Title: Improvement of Patient Safety and Quality of Inpatient Care through an Antimicrobial Stewardship Program

Hospital/System: Alexian Brothers Health System, Arlington Heights

Summary: In October 2010, the health system implemented an Antimicrobial Stewardship Program (ASP) that focuses on appropriateness of empiric antibiotics, de-escalation therapy, escalation of therapy, and the development of policies and protocols for the institution to help reduce bacterial resistance to antibiotics. Members within this program consist of infectious diseases physicians, surgeons, intensivists, an infection control practitioner, a microbiologist as well as administrative personnel.

A multidisciplinary approach has been developed with the addition of an infectious diseases pharmacist in August 2011. The infectious diseases pharmacist has been utilized for educating, delegating work and training select pharmacists at each hospital to attempt to streamline therapy, dose optimize antimicrobials and prevent misuse of many of the antimicrobials currently ordered at each hospital.

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Patient Safety and Quality: Medication Management

Project Title: Improving Patient Safety through the Implementation of Medication Bar Code Scanning

Hospital/System: Wabash General Hospital, Mount Carmel

Summary: Medication errors are a known patient safety issue. The hospital’s commitment to deliver high-quality care is what lead them to focus on decreasing medication incidents and ultimately improving patient safety. After implementing bar code scanning, they were able to see a 34% decrease in medication incidents hospitalwide.

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Patient Safety and Quality: Medication Management

Project Title: Reducing Door-to-Analgesia Time for Emergency Department Patients with Long Bone Fractures

Hospital/System: Abraham Lincoln Memorial Hospital, Lincoln

Summary: The purpose of this project was to reduce door-to-analgesia time for patients presenting to the Emergency Department (ED) with a long bone fracture (LBF). This project used Lean Six Sigma tools to identify process improvement opportunities via a revised empirically-based treatment algorithm. The goal was to reduce the mean time for administering pain medication for patients with suspected long bone fracture by 50%.

Results for the period Feb 2013 to June 2013 (N=25 patients) have shown a 57% improvement in mean time for delivering medication to long bone fracture patients' in the ED (from 44 minutes to 19 minutes) compared to baseline, with associated reduction in upper control limit as a measure of process variation. Thus, actual performance has exceeded the project goal.

As an extension of this project, pain management in all fractures has been optimized. Monitoring and education are ongoing at this time to ensure compliance and consistent process flow as part of the control phase of the project, with plans to extend this system to other health system Emergency Departments.

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Patient Safety and Quality: Medication Management

Project Title: Utilizing Pharmacy Technicians to Acquire Medication Histories and Appropriate Order Entry into the Electronic Health Record Resulting in Improved Patient Safety and Nursing Time Savings

Hospital/System: SwedishAmerican Hospital, Rockford

Summary: The hospital conducted a 12-week evaluation of the quality of medication reconciliation at the time of admission and discharge from the hospital. The accuracy of a patient’s medication regimen as documented in the electronic health record (EHR) was compared to what was identified through a medication history interview between a patient and a pharmacy technician. The hospital’s goals were to: 1) increase the accuracy of information documented in the EHR, and 2) assure all fields are updated in the EHR to improve the medication reconciliation process by the admitting physician. Traditionally, nursing staff is responsible for acquiring medication histories and physicians were responsible for the reconciliation.

Upon program initiation, a pharmacy technician became responsible for the collection of a patient’s medication regimen. An alert was created in the EHR which identified when a patient would be admitted from the Emergency Department. Upon the alert, the pharmacy technician would acquire all medication information available from previous admissions or from the outpatient EHR. Then, the pharmacy technician would interview the patient related to their medications. This allowed for identification of new medications and for confirmation of historical information. Upon completion of the history, the admitting physician is electronically notified that the medication reconciliation progress can begin. In the first six months, the hospital demonstrated significant improvements in the accuracy of the medication reconciliation process, improved patient satisfaction and achieved nursing time savings.

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Patient Safety and Quality: Mortality
Patient Safety and Quality: Mortality

Project Title: Reducing Mortality in Sepsis Patients

Hospital/System: St. Mary's Hospital, Decatur

Summary: The project’s goal is to reduce sepsis mortality using Crimson data to track and trend patterns and practice for the hospital’s medical staff, reducing length of stay and improving patient outcomes.

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Patient Safety and Quality: Quality and Safety for Physicians
Patient Safety and Quality: Quality and Safety for Physicians

Project Title: Primary Care Provider Survey

Hospital/System: Edward Hospital, Naperville

Summary: As part of the statewide Hospital Program Peak Performance (HP3) project, the facility’s hospitalist group created a survey for the medical practice primary care providers to gauge provider satisfaction with hospitalist services and identify areas for improvement. The surveys were distributed via email (Survey Monkey) and hard copies were mailed. Nursing unit managers and hospitalists were also asked for feedback.

Based on the data analysis, procedures were implemented to improve satisfaction with the hospitalist services. Changes made included: improvement to the discharge handoff tool; criteria for mandatory calls to the primary care providers; telephone contact information for the hospitalists provided to the primary care providers; hospitalists scripting; flyers distributed to the primary care providers with a description of hospitalist services; distribution of patient handouts with an explanation of hospitalist services; timely emails to the primary care providers within 24 hours of discharge; and maintenance of a consultant flowsheet.

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Patient Safety and Quality: Serious Adverse Events
**Patient Safety and Quality: Serious Adverse Events**

**Project Title:** Impact of a Comprehensive Patient Safety Strategy on Obstetric Adverse Events

**Hospital/System:** St. John’s Hospital, Springfield

**Summary:** The clinical leadership of OB/GYN and Newborn Services is focused on patient safety and risk reduction. The Birth Center and Newborn Intensive Care Units (NICU) are high-risk, 24/7 environments where good outcomes are expected. The hospital’s number one priority is to provide patient-centered, safe care with communication and teamwork embedded into the unit culture. The focus of this initiative was to reduce patient adverse events. The process selected to accomplish this was Crew Resource Management (CRM) training. Lifewings was selected as the hospital’s CRM implementation consultant.

The five-step process for CRM includes: leadership team development, customized skills-based training, hard wiring safety tools, initiating measurement tools, and achieving lifetime results. This parallels the Lean processes already imbedded in the organization’s culture and in particular the Birth Center and NICU. The philosophy statement developed by the leadership team that portrays the hospital’s expected outcomes is: “Our organization provides safe, quality care they would give their own loved ones. Physicians and staff achieve this through teamwork, collaboration and consistent adherence to protocol, seeking to continually improve with communication and feedback.”

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Patient Safety and Quality: Serious Adverse Events

Project Title: Sponge ACCOUNTing System - A Standardized Process to Account for Surgical Sponges was Implemented in an Effort to Reduce the Incidence of Retained Surgical Sponges

Hospital/System: Hospital Sisters Health System, Springfield

Summary: In fiscal years 2011 and 2012, the hospital system experienced seven retained surgical sponge events. A review of surgical count policies and procedures, and direct observation of counting practices, demonstrated a great amount of variation from one hospital to the next, as well as variation based upon personal preference and individual training. The goal was to improve safety and quality in the hospital’s surgical and procedural areas.

The hospital initiated the Sponge ACCOUNTing System. The change strategy included: educating leadership, train-the-trainer methodology, piloting the system in a small rural hospital, and roll-out training to the other hospitals. Sustainment activities included: just-in-time coaching; monthly calls to review miscounts, incorrect final counts and issues with implementation; quarterly audits; and quarterly observation visits by the system quality department.

Since implementation of the Sponge ACCOUNTing System, there have been no retained surgical sponge events.

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Patient Safety and Quality: Ulcer Prevention
Patient Safety and Quality: Ulcer Prevention

Project Title: Lean Six Sigma Methodologies Reduce Hospital-Acquired Pressure Ulcer Prevalence by 79% in a Tertiary Medical Center

Hospital/System: Memorial Health System, Springfield

Summary: The goal was to reduce hospital-acquired pressure ulcer (HAPU) prevalence by 50% using Lean Six Sigma methodologies. Process defects were identified for pressure ulcer prevention (PUP), including correctly identifying at-risk patients, initiating PUP interventions, achieving minimal turning requirements, and effective care coordination across units and shifts. Key improvements include: 1) development of a "PUP Kit" consisting of a PUP Bundle and bedside communication tools; 2) creation of "Team-Up to Turn" approach at standardized times with support tools; and 3) enhanced role definition and training for unit-based Wound Ostomy Champions.

Housewide hospital-acquired pressure ulcer (HAPU) prevalence rates for Stage I-IV ulcers have dramatically decreased from pre-intervention baseline average of 6.01% (Nov07 - Aug11) to 1.28% (Jan13 - Jun13), a 79% decrease in HAPU prevalence rate and exceeding our initial goal.

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Patient Safety and Quality: Ulcer Prevention

Project Title: SOS: Save Our Skin - A Pediatric Pressure Ulcer Prevention Program

Hospital/System: Ann & Robert H. Lurie Children’s Hospital of Chicago, Chicago

Summary: Infants and young children less than five years of age and children in ICUs are at the greatest risk for pressure ulcers. Other high risk pediatric populations are those with limited mobility, cardiac disorders with altered perfusion/oxygenation or lengthy operations greater than four hours. The most common site for pressure ulcers is the occiput in infants and toddlers and the sacrum in children. Occipital pressure ulcers have led to permanent alopecia, scarring, embarrassment, and body image disturbances. These injuries cause considerable harm, are painful and may lead to infection, sepsis, surgical intervention, and longer hospital stays. The cost of managing a single full thickness ulcer is estimated to be as high as $70,000. Hospital-Acquired Pressure Ulcers also impact reimbursement with the more severe ulcers (Stage III and IV) listed as one of the eight preventable conditions by the Centers for Medicare & Medicaid Services (CMS).

Most ulcers are preventable by identifying patients at risk and reliably implementing prevention strategies. In 2011, with the support of senior nursing and medical leadership, a Skin Care Committee was formed to identify the institution’s Pressure Ulcer Prevalence Rate. Based upon data results, the committee developed a Pressure Ulcer Prevention Program (PUPP) modeled after the successful 2010 Children’s Hospital Corporation of America (CHCA) Collaborative to decrease the hospital’s Pressure Ulcer Prevalence Rate. The PUPP program includes: staff education on patients at risk, individualized preventative care measures and pressure ulcer assessment, staging and care. This quality improvement program also includes unit skin care champions and ongoing data collection to monitor for compliance, sustainability and improved patient outcomes.

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