RWJ UNIVERSITY HOSPITAL HAMILTON

ROBERT WOOD JOHNSON HEALTH SYSTEM

Patients Receive Recommended Care for Community-Acquired Pneumonia

"For New Jersey to be a state in which all people live long, healthy lives."

DSRIP LEARNING COLLABORATIVE PRESENTATION

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The Care you Trust !

GROUNDS FOR HEALING

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Problem Statement

1. Patients present to the Emergency Department at high than desired rates.

2. Admission/readmission rates are higher than desired.

3. Repeat patients tend to be those with inadequate post discharge follow-up.

4. Repeat patients tend to be those with non-compliant medication use.

5. Identification of patients at high risk for readmission is not optimal.

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Objectives

OUR PROJECT GOAL IS TO PROVIDE :

- A set of strategies that will include design and implementation of standardized order sets
- Incorporate care based on recommendations by the Infectious Diseases Society of America and the American Thoracic Society consensus
- Utilize metrics that are measured by the Joint commission and CMS Pneumonia measure sets.
- Use strategies that will include the use of force functioning, prompt feedback to prescriber, and design and implementation of electronic health record in capturing and assessing compliance with initiatives.

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How we are to accomplish this ?

Develop a hospital-based program for patients with CAP that may include the following elements:

1) Develop a interdisciplinary team which include physicians, pharmacists, respiratory therapists
2) Determine interventions to be included in order sets
    - ER orders designed to include algorithm to identify appropriate care setting .
    - Medication order sets which include recommended medications and interventions as determined by the team.
    - Order sets that include diagnostic testing orders as determined to be appropriate by the team.
    - Smoking cessation and vaccine administration as appropriate for the patient.
3) Data and chart reviews to determine compliance with meeting performance measures and provide feedback to the physician.
4) Incorporate appropriate patients in the Care Transitions Program for post discharge care.
5) Work with outpatient partners for post discharge intervention to prevent readmission.

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The STEPS

STEP # 1:
Identified team members who are stakeholders in the care and treatment of patients with community acquired pneumonia.

- ✓ Project approved in early 2014.
- ✓Team members identified
- ✓ Team begin meeting to identify Interventions.
- ✓ Process developed for implementation.
- ✓ Protocols, algorithms and order sets developed.
- ✓ Met with Quality Improvement Director whose staff will monitor the team through the PDCA cycle.

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The STEPS

Step #2:

Meet with various individual stakeholders and community partners for education, feedback and buy in.

- ✓Partners were identified and contacted during development process.
- ✓Identified what would work and the necessary support for the program.
- ✓Identified barriers to providing care and insuring appropriate follow-up care.

The STEPS

STEP # 3

Send protocols and order sets thru the various Medical Staff Committees for approval.

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The STEPS

STEP # 4

✓ Begin education on roles of each discipline and community partners with the efforts that are being made to improve care for the patients with community acquired pneumonia.

✓Identify in their particular discipline the quantifiable & evidenced based interventions that need to be implemented .

✓Discuss the anticipate resulting improvement in outcomes for this patient population

The STEPS

STEP # 5

✓ Deploy the program
  ✓(slated for Mid October after final Medical Staff Approval.)

✓ Access impact.

✓ Adjust if necessary for variance encountered.

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Lessons Learned

- Nothing is as easy as it seems, each team member has a different perspective, different needs and different priorities.
- Each patient comes with their own set of perspectives, needs and priorities that need to be addressed.
- Partners add different individual issues with different patient populations regarding post discharge care for patient/families with CAP.
- Even with differences with each discipline and/or partner , everyone acknowledges the need for a coordination of care in order to improve patient outcomes.
- Electronic Communication is also not as easy as everyone would suspect.

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Our Success So Far….

- Creation of a multidisciplinary team that not only deals with a specific disease but with new means or coordinating care not only within our 4 walls but the extended care setting, the outpatient office and the home.
- Increased awareness within our own hospital of CAP treatment and the role we play in post discharge care.
- Improved and engaged dialogue with our outpatient partners.
- Engagement of our patients and their families as being part of not incidental to a positive outcome in their health and well being.

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Stuff that did not go so well…

- Feedback from CMS regarding the status of the project, placed approval timeframe into summer months when Medical Staff Committees take a break.
- Electronic communication between systems.
- Not fully understanding the Databook and how the attribution model affects data collection.
- Finding out we really did not understand how our data is being reported and spent unnecessary time developing data collection lines that we found out we did not

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What is next ?????

- Deploy the model we have created.
- Utilizing data and providing feedback to the different disciplines and stakeholders.
- Re deploy team members as needed to correct variances as they are identified.
- Engage providers and patients to participate improving outcomes and demonstrating that these changes benefit both the provider and the patient/family.
- Identify any factors/issues that undermine patient /family compliance
- Celebrate our successes.

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Obrigado!
Köszönettel
Gracias
ขอบคุณ
Bedankt
Teşekkürler
Hvala
THANK YOU
Grazie
Merci
Ευχαριστώ
Vielen Dank
شكراً
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