THE 2016 QUALIS HEALTH AWARDS OF EXCELLENCE IN HEALTHCARE QUALITY

Since 2002, Qualis Health has presented the annual Awards of Excellence in Healthcare Quality to outstanding organizations in Washington and Idaho. Winners have demonstrated leadership and innovation in improving healthcare practices, reflecting the very best in healthcare quality improvement. The awards recognize those who demonstrate outcomes relevant to the three broad aims of the National Quality Strategy:

- Better healthcare (for individuals)
- Better health (for populations)
- Reduced costs through improvement

Winners of the 2016 Washington Awards of Excellence in Healthcare Quality in Washington are selected by a panel of expert Washington stakeholders. Awards are presented at the annual Northwest Patient Safety Conference on May 4, 2016.

QUALIS HEALTH™

ABOUT QUALIS HEALTH

Qualis Health is one of the nation's leading population health management organizations, and a leader in improving care delivery and patient outcomes, working with clients throughout the public and private sectors to advance the quality, efficiency and value of healthcare for millions of Americans every day. In Washington, Qualis Health serves as the Quality Innovation Network–Quality Improvement Organization (QIN–QIO) for the Centers for Medicare & Medicaid Services (CMS), co-leads Healthy Hearts Northwest funded by the Agency for Healthcare Research and Quality (AHRQ), serves as the External Quality Review Organization (EQRO) for Washington Medicaid, and provides utilization and case management services to the Washington Department of Labor and Industries.

For more information, visit www.QualisHealth.org.

AWARD OF EXCELLENCE: POST-ACUTE CARE

Issaquah Nursing and Rehabilitation Center, Issaquah, Washington

Reducing Falls in a Skilled Nursing Facility

Submitted by: Lisa B. Stubenrauch, RN, Administrator

Fall injuries among the elderly can be debilitating, and are among the most expensive medical conditions in the United States due to associated hospital costs. Issaquah Nursing and Rehabilitation Center identified that 95% of their patients were at risk for falls. The facility's Quality Assurance and Performance Improvement team conducted systematic root cause analyses, utilizing data as well as input from residents, families and staff. Based on identified data trends and areas for improvement, the team implemented an improvement project with a goal to reduce patient falls to no more than 7% of residents. Their efforts included adjusting the nursing staff assignment and shift change process, initiating a "safety rounds" program at the beginning of each shift, improving reporting from the nursing staff to care teams, increasing awareness among residents and staff through Fall Prevention Day activities, fostering competition for fall prevention among care teams across different wings, and implementing a "community watch" program to improve staff observation of resident positioning and abilities. The result was a 26% relative reduction in falls, from 8.8% in 2015 to 6.5% in 2016, lower than their 7% goal.

AWARD OF EXCELLENCE: OUTPATIENT SETTING

UW Neighborhood Clinics, Seattle, Washington

Integrating Behavioral Health into Primary Care

Submitted by: Peter McGough, MD, Medical Director

As depression is a common diagnosis, and primary care provides the majority of care for patients with depression, UW Neighborhood Clinics sought to improve the outcomes of depression management. Most primary care providers refer their challenging patients to mental health specialists but face the barriers of poor coordination and limited access, resulting in many patients "falling through the cracks." These problems in care coordination result in suboptimal clinical improvement for nearly four of five patients started on antidepressant medications. UWNC partnered with the UW Department of Psychiatry to implement the Behavioral Health Integration Program (BHIP), a team-based, collaborative care approach involving the primary care provider (PCP), a care manager and a psychiatric consultant. Under oversight by the PCP, care managers provide comprehensive mental health assessments, patient engagement and education, evidence-based behavioral interventions, and proactive monitoring of treatment response. The model has resulted in significant improvement in the number of patients achieving care plan goals related to their anxiety or depression. More than 70% of patients with depression and 65% of patients with anxiety enrolled in BHIP have shown a 50% improvement in symptoms following a minimum of 10 weeks of treatment.

AWARD OF EXCELLENCE: SINGLE LARGE HOSPITAL

Providence St. Peter Hospital, Olympia, Washington

A Collaborative Transitions of Care Program for Heart Failure Patients

Submitted by: Stephen Gunadi, PharmD, Transition of Care Pharmacist

Preventing hospital readmission for heart failure patients is a nationwide focus, with 25% of heart failure patients rehospitalized within 30 days of discharge. Providence St. Peter Hospital recognized that medication discrepancies at admission and discharge were common, and addressed this issue by implementing a collaborative, pharmacy-led transitions of care program aimed at reducing readmissions of heart failure patients. The program focused on performing thorough medication reconciliation for all heart failure patients, including review of home medications at admission, conducting a readmission risk assessment, daily medication profile review, thorough assessment of discharge medications, filling prescriptions for patients prior to discharge, and providing bedside delivery of these medications with extensive patient education regarding medication therapy and lifestyle modification. Since the implementation of the transitions of care program at Providence St. Peter Hospital, their team has identified and corrected 531 medication errors at discharge, avoiding adverse drug events while maintaining a 30-day heart failure readmission rate of 15%, well below the national average of 22%.

AWARD OF EXCELLENCE: SINGLE LARGE HOSPITAL

Virginia Mason Medical Center, Seattle, Washington

A Clinical Decision Support Tool for Hospitalists: A Simple, Low-Cost Way to Improve Care for Patients Hospitalized with Myocardial Infarction

Submitted by: Drew Baldwin, MD, Heart Institute Quality Director

Cardiology guidelines recommend that a person hospitalized with a heart attack receive certain tests and treatments while in the hospital. The team at Virginia Mason Medical Center reviewed past data, saw that not all patients were treated with all the recommended care, and aimed to improve adherence with evidence-based guidelines. The target was to achieve overall defect-free care for greater than 90% of patients, which would be consistent with performance of the nation's top 10% of hospitals. To improve reliability, a multidisciplinary team created a clinical decision support tool that was implemented within the electronic health record in January 2015. The tool provides a short checklist of questions that the hospital physician answers when preparing the patient for hospital discharge. After hospitalists started using the reminder tool, there was a significant increase in the proportion of patients hospitalized with myocardial infarction who were treated with all the recommended care, from 80.8% to 94.6%. Based on success with this project, Virginia Mason has started using similar tools for patients hospitalized with other medical conditions.

AWARD OF EXCELLENCE: COMMUNITY ORGANIZATION

Verdant Health Commission, Snohomish County, Washington

Community Paramedicine: Improving Care and Connections for Vulnerable Populations

Submitted by: George Kosovich, Assistant Superintendent

For many people, the Emergency Medical Service (EMS) system and hospital emergency departments are the sole source of urgent and primary care. The community paramedic program gives EMS another option—dedicated paramedics who can follow up with frequent 9-1-1 callers and provide individualized support. Following a change in state law allowing fire districts and departments to work on non-emergency health needs, Snohomish County's Verdant Health Commission partnered with two fire departments in its service area, Snohomish County Fire District 1 and the City of Lynnwood Fire Department, to implement a community paramedicine program starting in 2014. For this program, Verdant funds two full-time paramedics and a part-time community resource specialist. Services provided to frequent 9-1-1 callers include in-home assessment of health risk factors, referral to primary care or social services, follow-up care coordination, and community health education. The project has demonstrated substantial improvements. Among program enrollees in 2015, 9-1-1 calls were reduced by 50% and ED visits fell by 43%. Just as important, the program has met patients' needs and connected them with a broad set of health and human services resources.