Goal 1: Improve the quality of life for residents of Reno County that are living with a chronic illness
Objective 1.1: Provide education to residents with Chronic Illness

Strategy	Timeframe	Responsibility	Potential Partners
Strategy 1.1.1: Provide chronic illness education via – brochures, telephone support, classes	March 2020 – March 2021 PHASE 1 – Congestive Heart Failure (CHF)	Director of CV Services	HRMC various dept Hutchinson Clinic Hospice and Home Health of Reno County (HHHoRC) Prairie Star Healthcare
Strategy 1.1.2: Provide post discharge education to chronic illness patients that are un-insured via Community Care program	July 2020 – June 2021 PHASE 1 – Congestive Heart Failure (CHF)	Community Care Clinical Liaison	HHHORC, HRMC - Care Management, Sound Physicians, HRMC - Cardiac Rehab and Pulmonology dept
1.1.3 Develop methods to track patients that are admitted to the hospital with chronic illnesses.	July 2020 - March 2021 PHASE 1 – Congestive Heart Failure (CHF)	Director of CV Services IS department	Hospice and Home Health of Reno Co. Care Management Dept Sound Physicians Hutchinson Clinic Prairied Star Healthcare
1.1.4 Develop work flow to provide follow up calls to chronically ill patient on discharge day 1 and 3, to evaluate education needs and discharge plan of care.	July 2020 – June 2021 PHASE 1 – Congestive Heart Failure (CHF)	Director of Care Mgmt	Hospice and Home Health of Reno Co. Care Management Dept Hutchinson Clinic Prairie Star Healthcare

Outcomes & Measures
Process Indicators

- # of new diagnosed CHF patients that were referred to a post discharge program
- # of CHF patients with minimal resources that are referred to the Community Cares program

Outcome Indicators

- Number of community members provided education by at least one format for a chronic disease
- Number of patients called post discharge with a diagnosis of CHF
- Number of patients with CHF referred to Community Care
- Number of patients with CHF in Community Care program with no readmission in first 30 days

Metric 1.1	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of Community member provided chronically disease education by at least one format													
Record format education was provided via (fair, Sr Center etc)			In-person education given on coronary artery disease to Civitan group & 1st Course (approx. 300 attended)	Radio show (KWBW) interview/education covering CAD, PAD, diet & exercise information	Soroptimist health fair (medication, smoking cessation, COPD) approx. 75 served)								
% of CHF pts dismissed from hospital that recd a post discharge call	Position was eliminated												
% of new diagnosed CHF pts referred to the Community Care program													
% of CC program patients that did not readmit in 30 days													

# of CHF patients received CHF education while in hospital	50%								80%	52%	64%	71%	100%
# of CHF patients accepted in the CC program													
# of CC program patients that did not readmit in 30 days													
% of CHF readmissions (per ClinView database)													

Metric 1.1	Benchmark	Jan 2021	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of Community member provided chronically disease education by at least one format													
Record format education was provided via (fair, Sr Center etc)			In-person education given on physical exercise to Civitan group (approx. 50 attended)	Radio show (KWBW) interview/education covering COVID/CAD, diet & exercise information									
% of new diagnosed CHF pts referred to the Community Care program													
% of CC program patients that did not readmit in 30 days													
# of CHF patients received CHF education while in hospital	50%	25%	28%	70%	85%	100%	75%	100%	100%	100%	100%	83%	75%
# of CHF patients accepted in the CC program													
# of CC program patients that did not readmit in 30 days													

% of CHF readmissions (per ClinView database)													

Metric 1.1	Benchmark	Jan 2022	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# of Community member provided chronically disease education by at least one format													
Record format education was provided via (fair, Sr Center etc)			In-person pacemaker education given to Civitan group (approx. 50 attended)										
% of new diagnosed CHF pts referred to the Community Care program													
% of CC program patients that did not readmit in 30 days													
# of CHF patients received CHF education while in hospital	75%	100%											
# of CHF patients accepted in the CC program													
# of CC program patients that did not readmit in 30 days													
% of CHF readmissions (per ClinView database)													

NOTES

Facility	Date	Notes
	Jan 2020	Readmissions task group minutes: CHF order sets will determine our focus group ● Will send at least every other week email to group on updates of progress ● Bring denial team member in to discuss financial impact on denials for CHF patients Set a goal of readmits from 27% to 24%
	Feb 2020	CHF order set completed 2/11, must got to MEC

		• CHF Readmits in 30 days for month of December was 16.7%. • 7 day readmits were 5.6% • Rhonda and Katie are working on the standardized CHF education. No completion date set at this time. • Pharmacy will be concentrating on the discharge medication reconciliation for all CHF patients once order set in place. The order set will task them as a consult. Pharmacists are going through a 2-part education series. Roger also provided info on where to find cost of medications for pt in Cerner (such as if drug is tier or formulary)
	March 2020	Follow up made with Erin Korb, Hutch Clinic's Care Navigation (chronic condition program). They are starting this week by sending letters to their patients to enroll them • Nicole reports John is currently working on building the updated CHF order set in Cert. Once this is approved it will move into Prod. There has been a task set up to send the pharmacists a notification that counseling is require.
HRMC	June 2020	6/16 HRMC - CHF order set has been approved and beginning to be used in the hospital. The order set has a Day 2 task to consult dietary, Cardiac rehab and pharmacy for education in the hospital. Care Mgmt will monitor CHF patients and consult the Community Care program for supportive care in the home for up to 30 days s/p discharge. The hospital is paying for the charge for this program. Care Mgmt will meet with the patient prior to discharge and review POC and then f/u with a call s/p discharge to ensure the POC is working and provide any additional information needed. • CHF order set available in place but not being utilized much. Lori Bortzfield is checking with the hospitalist group to see what barriers exist for using them. Noted that the order set is only being used for CHF primary dx. Aubrey working on report so we can tell how often order sets are being used.
	July	Pharmacy piloting a program to add pharmacist in ED & 5300 to help with med rec to decrease medication rec errors • CHF order set used 10 times the month of June and 6 times during first part of July. • Jarrod reports our data shows we keep CHF patients ½ day shorter compared to the GMLOS. CC patients are 1.0 day shorter with a readmission rate of 25%. • Most readmits are occurring within 15 days of discharge. CHF readmits volume so small so difficult to make a big impact. If we decrease one CHF readmit a month then we will fall below 20%. CHF order set working well for tasking and education.
HRMC	August	8/20 HRMC – Finalizing CHF order set for use. HRMC created program for those that are un-insured to provide 30 day f/u for education and assessments in the home, will also be calling at 24 and 72 hours to ensure the POC is meeting the pt needs. • In July, order set used 9 times and so far in August it has been used 3 times. • For 2020, there have been 24 out of 81 CHF patients readmitted • Readmit rate through May was 28% • Hutch Clinic starting "population health". Once this is up and running, Lori will follow up to see what program offers and if there are opportunities to partner • Prairie Star – no program we are aware of but reported they are willing to collaborate with the hospital Home Care of Reno County – they have Community Care program but this is only for patients who would not qualify for home health. It was explained most patients have home health benefit and quality so that is offered more than the Community Care

HRMC	Sept 2020	9/17 HRMC – Use of the CHF order set has been variable. Determined some issues: Changed the title to decrease confusion as to how it can be used. Working with the HRN to determine further issues on work flow for the order set. Establishing a process to review every case for order set was not used. Continue to review every readmission for CHF for opportunities in improvement of care. ● Discussion held on discharge medication list and physician instructions not being printed on the sheet. These instructions will only print if they were documented in the "note box" and not "special instructions" ● Physician instructions has to be placed in the "ERX to Pharmacy" in order for the patient's retail pharmacy to view them
HRMC	Oct 2020	10/15- Name of CHF order set changed to remove the word "Admission". However, it was realized the query was now not pulling pt data to report. Working with IT to correct. Aubrey finalizing CHF Bootcamp proposal to present to foundation for funding. ● CHF order set being used more frequently ● New focus with Readmission Task Force: will be looking at 7 day readmits, regardless of diagnosis ● Kim will send weekly list to taskforce group so close to real time situations can be assessed, looking for trends and opportunities to prevent readmissions
HRMC	Nov 2020	11/19- CHF order sets and education are being used and provided. Grant for CHF boot camp was not able to get on Nov. Foundation meeting, will present in January. 2 out of 4 patients appear that readmission had opportunities that may have lowered risk of readmission: ● Home medication not restarted Patient non-compliant with physician recommendations ● Discussion held around home medication list and process to verify including importance of reviewing home meds prior to dc. ● If doctor wants a med ordered at dc'd, it can be ordered prior to dismissal and not activated until day of discharge. ● Per sw assessments on readmissions, patients are voicing they received education on their disease prior to discharge, did pick up new prescriptions and saw pcp for f/u.
HRMC	Dec 2020	Meeting cancelled due to high volume of COVID patients at HRMC
HRMC	Jan 2021	Order sets and education are being used and provided. In review of the 7 day readmits no issues with these two factors have been determined. HRMC Foundation approved a grant for the CHF Boot Camp, it is with Compliance now ● Current readmission rate: 13% for all dx and 19% for CHF
HRMC	Feb 2021	CHF Boot Camp is still with Counsel, cardiac rehab continues to provide CHF education to patients in hospital & working with hospitalists identifying patients in need of education, reviewing 7-day hospital readmissions. HRMC readmissions task group reviews Discussed Med to Bed program and if this is something we can explore. Nicole states this has been looked into and the only way to set this up is to either be a retail pharmacy or distribute medications at no cost.
HRMC	March 2021	Pharmacists in ED, ICU, & 5 th floor. HRMC added 2 med rec pharmacy techs to verification of medication rec to decrease admission medication rec errors. Discharge medication education provided by pharmacist M-F Starting March 29th, multi-disciplinary rounding will begin and this may help pharmacy and nursing with providing the dc education prior to patient leaving.

		● 7-day readmits reviewed. Majority of these patients were discharged from first visit to a snf or home w/home health. ● No specific trends or missed opportunities noted from these 7-day readmits. Discussion held on post covid patients and if there will be any trends. This will be something to follow and monitor.
	April 2021	● New pilot program getting ready to start on 5100 – nurse navigator. Role will be to help with admissions, discharges and on-going education through the patient's stay. Education material at discharge is being formatted by IS to include all education relative to patient dx, in easy to read/understand format ● 10 patients reviewed: no overall trends found. ● Some had multi-factors/complex medical needs All met goals of care at initial discharge ● **30-day readmission rate YTD: 14.2%** Target goal: 15.3% ● **CHF 30-day readmission rate YTD: 23.3%** Target goal: 21.7% ● **COPD 30-day readmission rate YTD: 11.4%** Target goal: 19.6%
HRMC	May 2021	CHF Boot Camp only available to indigent patients due to compliance regs start July 1. Continued monitoring of CHF patient education and readmissions.
	June 2021	**Current data:** ● **30-day readmission rate: 10.7%** Target goal: 15.3% ● **CHF 30-day readmission rate: 12.3%** Target goal: 21.7% ● **COPD 30-day readmission rate: 7.1%** Target goal: 19.6% ● Update on 5100 Nurse Navigator: working very well when fully staffed and not having to pull her to the floor. Nurse navigator has been focusing on admission and discharge of patients with on-going daily education, targeting CVA and CHF patients ● Education discharge material reformatted by IS update: education material has been put in same place so easier to find. Medication education not being printed out with discharge instructions.
	July 2021	EMAIL readmission meeting- 7-day readmits for review. No specific trends reported at this time. ● **30-day readmission rate: 10.3%** Target goal: 15.3% ● **CHF 30-day readmission rate: 33.3%** Target goal: 21.7% **COPD 30-day readmission rate: 25.0%** Target goal: 19.6%
	Aug 2021	● Pharmacy is looking at options to help cover cost of medications for indigent patients, specifically the foundation ● Pharmacy and care management can give approval to dispense medication at no-cost to patient if it is under $200.00 Some high-cost meds that are tasking care management and pharmacy are not getting addressed with patient prior to discharge to ensure they are able to afford it – education reminder needed. ● F/U appointments are not always being made for patient, especially if there isn't a unit clerk. ● Length of time on phone to make appointment can be time consuming ● Lori B will reach out to Hutch Clinic liaison to see if they can assist to ensure appointments are being made

		Care management can assist if staffing/time allows ● CHF order set is usually being used on admission and not after arrival. Discussion held on getting order set to be used whenever it is appropriate during course of patient's stay. Discussion held on no pharmacy being listed on patient's profile. If it is not listed it will go into default and prescription will not go through to fax. Karla will look into changing default so pharmacy has to be listed prior to medication being prescribed. ● **30-day readmission rate: 10.3%** Target goal: 15.3% ● **CHF 30-day readmission rate: 33.0%** Target goal: 21.7% ● **COPD 30-day readmission rate: 25.0%** Target goal: 19.6%
	Sept 2021	● Care management and pharmacy are now able to authorize filing discharge medications for patients who do not have access to obtaining medications d/t no pharmacy open, indigent, etc. This is a case by case basis and when all other options have been exhausted. ● Most of 7-day readmits were set up with either home health or went to a nursing facility. ● Majority were able to get medications filled and if enough time lapsed between admissions were able to see their pcp. ● **30-day readmission rate: 10.4%** Target goal: 15.3% ● **CHF 30-day readmission rate: 25.0%** Target goal: 21.7% ● **COPD 30-day readmission rate: 33.3%** Target goal: 19.6%
	OCT 2021	● Hutch Clinic has hired a new liaison, She will start in November and will provide post-discharge follow up phone calls and assist with getting patients scheduled to see pcp. Prairie Star is providing post-discharge f/u calls to patient. They are getting patients into pcp approx. 2 weeks after hospital discharge but will schedule sooner per hospital request. Tele-monitor consult for all CHF/COPD patients still being looked into. Determining who the task goes to, who oversees the monitoring and which patients would be appropriate is still undecided. Hospitalist and cardiology are getting ready to start-up sub-committee to discuss CHF protocol, order sets and if any areas need revamping. 7-day readmits reviewed. No specific trends/opportunities found ● **30-day readmission rate: 10.1%** Target goal: 15.3% ● **CHF 30-day readmission rate: 17.1%** Target goal: 21.7% ● **COPD 30-day readmission rate: 16.7%** Target goal: 19.6%
	Jan 2022	● 7-day readmits reviewed. Noted some were due to patient being non-compliant ● There was no trend based on which nursing facility, home health agency patient had at discharge, or if they were discharged home without services. Noted 10 out of 18 readmits did receive either home health or placement at first discharge. ● For now, will continue to focus on 7-day readmits since this is an area where we can have most impact. ● Pulmonary rehab being auto-consulted for pneumonia, asthma and COPD order sets. There is benefit in patients having this service at discharge so would like to see number in referrals increase. CHF order set – workflow process.

		• **30-day readmission rate: 10.2%** Target goal: 15.3% • **CHF 30-day readmission rate: 18.7%** Target goal: 21.7% • **COPD 30-day readmission rate: 20%** Target goal: 19.6%
	Mar 2022	**Current data:** • **30-day readmission rate: 8.4%** Target goal: 15.6% • **COPD 30-day readmission rate: 50%** Target goal: 19.7% • **AMI 30-day readmission rate: 6.3%** Target goal: 15.8% • **HF 30-day readmission rate: 0.0%** Target goal: 21.9%
	April 2022	Current data as of January 2022 30-day readmission rate: 12.4% Target goal: 15.5% (BCBS target goal is at or below 10%) COPD 30-day readmission rate: 0% Target goal: 19.8% AMI 30-day readmission rate: 0% Target goal: 15.8% HF 30-day readmission rate: 100.0% Target goal: 21.9% Pneumonia 30-day readmission rate: 20% Target goal: 16.7% It was noted that education is one area where improvement can be made for these patients. Cardiopulmonary rehab is rejuggling staff duties to help with education prior to HF patient's discharge. Discussed focusing on COPD, Pneumonia and HF 30-day readmits rather than 7-day for upcoming meetings. BCBS QBRP has set a goal of all cause readmits to be at or below 10%. Discussion held that our target goal should be in sync with BCBS Care Transitions and Readmissions Reduction from Compass HQIC reviewed. This is a collaboration with Compass to see where there are opportunities for interventions. Implementation of discharge planning checklist and bedside huddles conducted with engagement of patient/family are two areas of opportunities from HQIC best practice. Discussed what new process for Multi-Disciplinary Rounding will look like. It is anticipated to start in May and start on one unit as a trial before rolling out to rest of the units. MDR will be done on the unit so staff can more easily participate. Physicians will also be unit based. Focus will be on 30-day readmits for patients who have HF, COPD and Pneumonia rather than the 7-day readmits. Will return to monthly meetings to capture more real time issues/opportunities.

		Pulmonary rehab consult is on the standing order form and is auto checked. It was noted that some physicians will unmark the pulmonary rehab consult so not all COPD patients receive the referral. Aubrey reports about 30% of referrals are eligible for services.	
	May 2022	**<u>Current data as of March 2022</u>** **30-day readmission rate: 9.2%** Target goal: 15.3% (BCBS target goal is at or below 10%) **COPD 30-day readmission rate: 50%** Target goal: 19.6% **AMI 30-day readmission rate: 5%** Target goal: 15.7% **HF 30-day readmission rate: 13%** Target goal: 21.7% **Pneumonia 30-day readmission rate: 29%** Target goal: 16.6% Review completed on the HF readmission patients. No trends noted. Non-compliance was a factor for one patient. It was noted that one patient had follow-up appt with pulmonologist and pcp prior to readmission and if patient was able to make those appointments. Karla will look into adding “outside record” tab to care management so this information can be found on patients. Noted that one patient, who had home medications in pharmacy, did not leave with them at discharge. She was readmitted one day after discharge so likely not a factor in readmission but led to discussion on tasking staff on checklist items at discharge. Kelli discussed how 4400 unit writes this reminder on their huddle board so staff review prior to dismissing a patient. Suggestion made that all units try this. Discussion held on the Readmission Risk assessment in the EMR that social workers complete and which departments would find it useful to have this info with a point system to help determine who may be at risk. Multi-disciplinary team huddle involving all ancillary departments involved with care of patients overall has been working well. Goal is to roll out next unit in June, with plan to eventually have this process on ICU, 3300, 4400 and 5100.	

	Jun 2022	**<u>Current data as of March 2022</u>** **30-day readmission rate: 9.2%** Target goal: 15.3% (BCBS target goal is at or below 10%) **COPD 30-day readmission rate: 50%** Target goal: 19.6% **AMI 30-day readmission rate: 4.8%** Target goal: 15.7% **HF 30-day readmission rate: 12.5%** Target goal: 21.7% **Pneumonia 30-day readmission rate: 28.6%** Target goal: 16.6% Outside Record tab is now in place for care management to view patients follow-up appointments, outside encounters & medication history. This will assist in completing the Readmission Assessment. Pharmacy is now being tasked if it is marked on Readmission Risk Assessment that patient takes 7+ home medications, is unable to afford their medications and/or has 2+ co-morbidities that include CHF, AMI, COPP and Pneumonia. 400 unit continues with MDR since beginning of May. There is a good work flow with bedside rounding and group meetings. Overall, there is a favorable response from staff who are involved. 5100 unit started MDR beginning of June. The process and flow are still being worked on. It was noted that participation from staff has not been consistent but is improving.	
	Jul 2022	**Readmission Rates** |	Goal	March - 22	April - 22 | |---|---|---|---| | 30-Day All Cause | 10.0% | 9.2% (34) | 9.6% (37) | | COPD | 19.7% | 50.0% | 40.0% |	

		AMI	15.8%	4.8%	10.5%	
		HF	21.9%	12.5%	33.3%	
		PN	16.7%	28.6%	11.1%	
		CABG	12.6%	0.0%	25.0%	
		Readmission Taskforce expanding group to include partnership with our community providers for collaboration to decrease readmissions. **Brooke Stover, Chief Operating Officer, with Hutch Clinic provided introduction and insight on ways they are can partner with the hospital.** **Information provided on services Clinic can assist with including: post-discharge follow-ups, expedite f/u appointments for patients when needed and care navigator contact information.** **June data reviewed and total of 23 readmissions with pneumonia being top dx (3 patients).** **It was noted the 30-day all cause readmissions goal has dropped to 10%, to align with BCBS goal vs previous goal of 15%** **Disposition after discharge data showed 54% went home after first dismissal, 13% had home health, 29% went to care facility and 4% transferred to higher level of care.** **Discussion held on the 54% that went home without services. From review, Kim R. highlighted that some charts showed services offered/recommended and patient declined. It was suggested when home health is recommended and patient refuses to let provider know so further discussion can occur prior to discharge.**				

Nursing view on Cerner does not easily show when a patient is a readmission but Care Management is able to see on their work list. Kim R will reach out to IS for options for nursing view.

Sept 2022

Readmission Rates – ClinView

	Goal	May - 22	June - 22
30-Day All Cause	**10.0%**	**8.3% (31)**	**6.7% (28)**
COPD	**19.7%**	**0.0%**	**25.0%**
AMI	**15.8%**	**11.8%**	**8.3%**
HF	**21.9%**	**8.7%**	**0%**
PN	**16.7%**	**0%**	**15.8%**
CABG	**12.6%**	**0.0%**	**0.0%**

		Readmissions for all cause was 9.8% which was an increase but our volume was up. Doing well with our 10% goal. Kyle shared data from ClinView on the top readmissions for May and June (data in graph on first page of minutes). The top three are sepsis, hypertensive heart & CKD w/ heart failure and pleural effusion. From the 48 readmissions in August the majority were discharged to home. Home without service review shows 13 declined or had other services in place, 14 did not show home health was suggested and 1 was unknown. When social workers do assessment they specifically ask or say this is the services already in place. One was unknown because there was no follow-up. This was a learning opportunity for her team and they are now suggesting home health. **The hospitalists feel they are getting referrals from some providers more than others, soft admits. Feel a few are always admitting their patients. This was reviewed and we are not seeing a trend. Those that seem to request to admit a lot of patients are seeing a lot volume wise.** **Many of the 48 re-admissions had a very short length of stay. Those with 1-3 day stays are the most common readmits. Goal is 4.3-day LOS and we are right at that.** **There are still many issues with medication reconciliation.** **The units where the majority of readmitted patients were at when discharged were 3300, 5100 and 5300.** **Mobility study shared. They don't focus on the patient's diagnosis, they focus on the patient's mobility. This is an opportunity for her team to work on, if they are going home, they need to get home health set up for them. Lori stated PT can put an order in but the physician has to sign it. Have done DTA (Cerner field on power form) on forms if recommend therapy on discharge it will give Social Services a consult.** **Twenty of the readmits were diabetic and 14 had substance abuse concerns. We are working on services for substance abuse. ED is starting a cage assessment – if score a certain number will do interventions to get them in a program or supportive services, not just alcohol but any substance abuse.** **Social workers do a deep dive with readmissions (readmissions root cause) with the patient and/or their family. Asking questions re: education.** **Clerks make most of the discharge appointments, usually within 7 days unless told otherwise. Brooke stated their problem has been staffing. PrairieStar reps haven't had any issues. They try to get appointments for the same day. The difficult ones to get scheduled are those that leave after hours or weekends. Brooke stated they are working on an after-hours number to call, but**	

		it is also a staffing issue. Would like to be able to call and get them a morning appointment w/PCP instead of coming to the ED. PrairieStar also follows up if they know about the patient. **There has been an increase in patients that don't have their PCP on their paperwork. If the patient chooses not to have their PCP notified then it's not filled in. If it is completed Dr. Johnson and Brooke said they automatically get a fax. The patient needs to know it is important for us to have to provide care afterwards. If can put in PrairieStar or Hutch Clinic and not doctor at least they would get it.**	

Objective 1.2: Increase the proportion of chronically ill residents receiving the appropriate vaccinations.			
Strategy	Timeframe	Responsibility	Potential Partners
Strategy 1.2.1: Participate in the state-wide initiative on tracking all vaccinations through the state WebIZ that are provided by the Clinical CHIP organizations	July 2020 – March 2021	Clinical CHIP members	HRMC Hutch Clinic Prairie Star Summit RCHD Long Term Care Facilities
Strategy 1.2.2: Develop infrastructure to post and retrieve information from Web IZ	July 2020 – March 2021	Clinical CHIP members	HRMC Hutch Clinic Prairie Star Summit RCHD Long Term Care Facilities
Strategy 1.2.3: Provide, track and trend patients with a chronic illness an develop mechanisms to ensure vaccinations are appropriate, i.e. Influenza, Pneumo Vac, Prevenar, Hepatitis, Tetanus	2021	Clinical CHIP	HRMC Hutch Clinic Prairie Star Summit RCHD Long Term Care Facilities

Outcomes & Measures
Process Indicators
● Number of Clinical CHIP members that are able to submit to retrieve information from WebIZ

Outcome Indicators
• Number of Clinical CHIP members that retrieve vaccine information from the State WebIZ site.

Metric 1.2	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of CHIP members with established programs to submit and retrieve information from WebIZ	HRMC Hutch Clinic Prairie Star RCHD												

NOTES

Facility	Date	Notes
HRMC	June 2020	6/16 HRMC - HRMC Web IZ is established in EMR, still waiting on testing and confirmation from WebIZ on flow of information to and from. HRMC working on an auto abstraction of patients that meet the criteria for influenza and PNE vac and determine what % are actually getting the vaccinations that are required for their age. HRMC = Initial thoughts of having a program that would provide education to the patient of key Health Preventive tests that are needed for their age or diagnoses.
HRMC	Sept 2020	9/17 HRMC – Vaccinations for the chronically ill will start by developing a process to get vaccinations provided to appropriate age groups and meeting state requirements of logging the vaccinations that are given in the state WebIZ program.
HRMC	Oct 2020	
HRMC	Nov 2020	11/19- Mickey reported the progress on being able to submit vaccinations to Ks WebIZ. We have two EMR products that are needing to submit. We are submitting data from both but we have identified an error that Cerner is needing to address. Once that is resolved, we should be ready to actually test with WebIZ, if that goes well we will be able to activate the program. This will include vaccinations from July 2020 through current date and going forward.
HRMC	Dec 2020	Meeting cancelled due to high volume of COVID patients at HRMC
HRMC	Jan 2021	Started giving COVID vaccines to staff in December, continuing to submit data to WebIZ, working out IT issues
HRMC	Feb 2021	Continued to give COVID vaccines to staff members, and working with RCHD, PrairieStar, Hutch Clinic
HRMC	Mar 2021	Partnering with RCHD, PrairieStar, Hutch Clinic to give COVID vaccines to staff members. Volunteering w/ RCHD giving public COVID vaccines.

Goal 3: Reduce the opioid impact on Reno County

Objective 3.1: Decrease the opioid prescribing by 20%

Strategy	Timeframe	Responsibility	Potential Partners
Strategy 3.1.1: Develop data collection methods to monitor opioid prescribing	July 2020 – December 2020	Clinical CHIP	HRMC Hutch Clinic Prairie Star Summit
Strategy 3.1.2: Develop methods to assess KTRACs prior to each opioid script that is written	July 2020 – December 2020	Clinical CHIP	HRMC Hutch Clinic Prairie Star Summit
Strategy 3.1.3: Provide education to providers on alternatives for pain management	July 2020 – June 2021	Clinical CHIP	HRMC Hutch Clinic Prairie Star Summit
Strategy 3.1.4: Provide education and medication management to Community Care patients following discharge from HRMC	July 2020 – June 2021	Community Care Clinical Liaison	HRMC HORC
Strategy 3.1.5: Grant for writing the program to abstract opioid data from the Cerner EMR at the hospital	July 2020 – Dec 2020	Jarrod Urban	HRMC

Outcomes & Measures
Process Indicators
● Improve understanding of prescribing options for pain management through number of interactions with KTRACs ● Improve understanding of prescribing options for pain management through number of practitioners attendance to education programs ● Development of standardized opioid education materials for use in Community Care program ● Improve the monitoring of opioid impact to the patient population served at HRMC

Outcome Indicators
● Decrease opioid prescribing in healthcare facilities ● Number of Community Care patients whose opioid risk is assessed ● Development of an Opioid dashboard for HRMC

Metric 3.1	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of opioid scripts that have a KTRAC review prior to giving to patient													
# of opioid meds on the home med list													
# of opioid meds on the discharge med list													
% of decrease in opioid meds between home and discharge med list													

NOTES

Facility	Date	Notes
HRMC	June 2020	Application for a grant through KHC granted to pay for programing of dashboard from HRMC EMR related to Opioid metrics
	Sept 2020	Grant for the abstraction program within the hospital EMR has been completed and the program is allowing a new evaluation of opioid prescribing and management from the acute setting. Currently we have determined that we have given more Narcan than we did in all of 2019. We have determined that we have had at least 8 overdoses (although the feeling is that we have had more but the coding at discharge was under a different DRG). Working on assessment of the number of opioids are on the Home Med List and the number that are on the Discharge Med List. Second focus for this next month will be on investigations into Adverse Drug Events.
	Nov 2020	Beginning to get some consistent data from the EMR in the hospital. The Opioid Stewardship Committee will review the data for opportunities and will be also looking at the volume of scripts sent home with opioids. Continuing to work on practitioner access to KTRACS prior to writing an Opioid Scripts.
	Jan 2021	Ad-hoc meeting to discuss implementing SUDS contact info into our Discharge Education. Recovery Response Team ● Funded by grant directed by Bureau of Justice Assistance for Rural Response to Opioid Epidemic ● Partnership with Reno County Health Department ● Based on notification by local health-care providers and community members, the Recovery Response Team's mission is to respond to any overdose or relapse in Reno County within 24-48 hours of the event regardless of the substance involved

- The goal is to quickly connect the community member and their family-system to resources that assist with treatment, increasing social capital, community capital, stable social/relational interactions and improved self-efficacy
- Customized to the individual and their circumstances regardless of payor source and patient/client status within the HRMC system

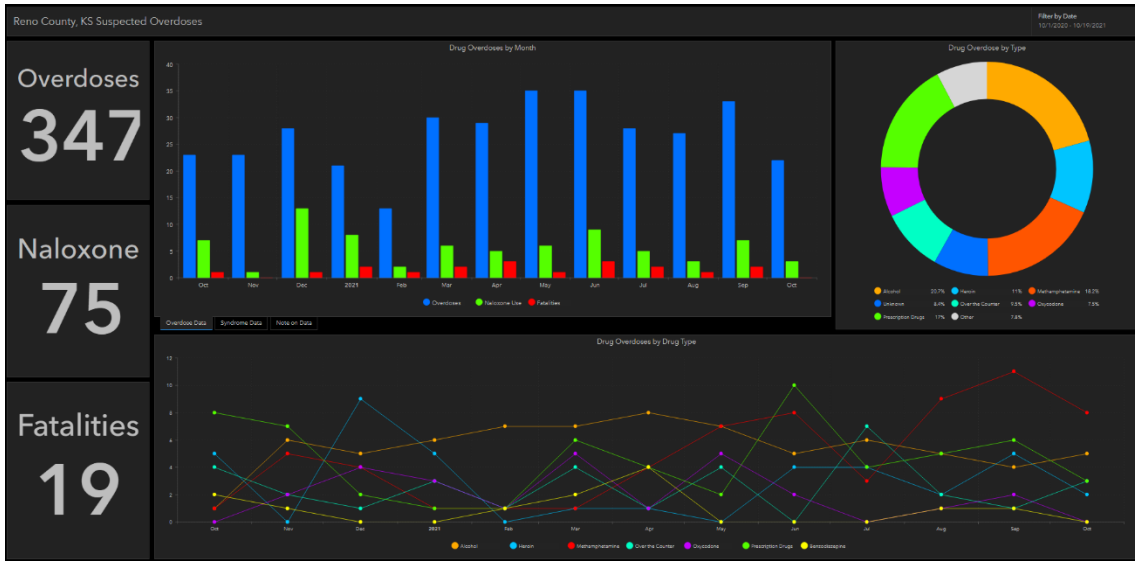
FEB 2021

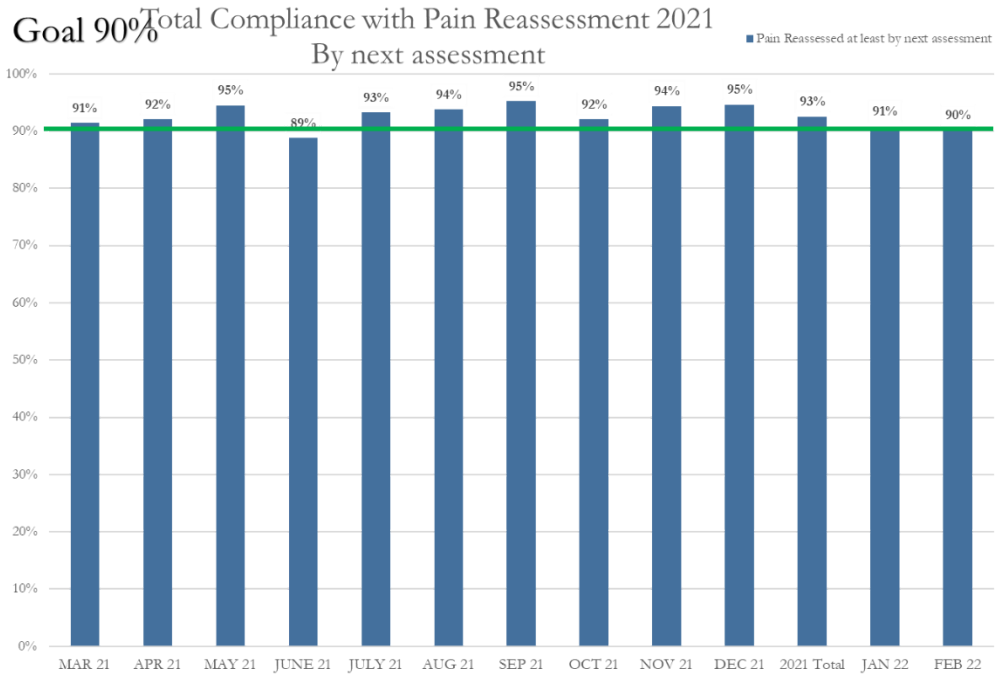
Narcan Education, Kim will send out information for free Narcan and the education slides. CDC is recommending everyone carry Narcan and recognize over dose. Kim reported that Seth had mentioned there were about 60 by-standard Narcan given, but there is no record in OD tracking of this number. One item that was emphasized was when they call 911 just to say there was a person down, but not that you suspected an overdose. The team speculated that was due to preventing a police response. Review of Pain Management and Opioid Stewardship Dashboard.

JUL 2021

MOSS (Michigan Opioid Safety Score) implemented in HRMC and built into HER, building report also on non-pharmacologic interventions
July 1, 2021- all narcotics must be prescribed electronically and can no longer be written on paper scripts in HRMC

Metrics	Target/ Threshold	FEB 20	MAR 20	APR 20	MAY 20	JUNE 20	JULY 20	AUG 20	SEP 20	OCT 20	NOV 20	DEC 20	2020 Total	JAN 21
Pain Reassessed (30 min IV - 60 PO) Sample	90%	73%	70%	73%	69%	73%	70%	71%	72%	75%	71%	68%	69%	75%
Pain Reassessed at least by next assessment	90%													87%
Number of in/out patients prescribed an opioid (excludes lab & x-ray)		687	603	461	521	681	642	574	645	641	581	567	**7277**	621
Rate of Opioid prescribed to above patient types.	<25%	24.3%	23.8%	27.1%	24.6%	27.8%	25.6%	23.6%	25.5%	24.6%	24.0%	24.2%	24.6%	26.9%
Number of patients with Narcan administered		6	9	6	5	8	4	14	9	9	5	7	**89**	7
- Number of Narcan doses administered (All areas)		9	17	7	5	11	14	20	13	13	6	14	**139**	10
- Community Onset (Narcan as a result of OD prior ot arrival, both intentional/non-intentional)		6	15	5	3	7	13	8	9	12	5	6	**99**	10
- HRMC Related to over sedation (pain meds)		3	2	0	2	2	0	8	1	1	1	0	**20**	0
- Moderate Sedation		0	0	2	0	0	0	1	0	0	0	0	**3**	0
- Related to Surgery		0	0	0	0	2	1	1	1	0	0	8	**13**	0
-Treatment plan (tried for unknown unresponsiveness- not effective)		0	0	0	0	0	0	6	3	5	2	8	**24**	2
- High risk patients for oversedation									7	7	4	7	**25**	5
- High risk patients with mitigation applied (EtCO2, pulse oximeter)									7	7	4	7	**25**	7
Adverse Events related to opioids (RL6)	0	0	0	1	0	0	1	1	1	0	0	0	**4**	0

	Oct 2021	**Metrics**	**Target/ Threshold**	**OCT 20**	**NOV 20**	**DEC 20**	**2020 Total**	**JAN 21**	**FEB 21**	**MAR 21**	**APR 21**	**MAY 21**	**JUNE 21**	**JULY 21**
		Pain Reassessed (30 min IV - 60 PO) Sample	90%	75%	71%	68%	69%	75%	81%	78%	82%	86%	79%	78%
		Pain Reassessed at least by next assessment	90%					87%	94%	91%	92%	95%	89%	93%
		Effectiveness of pain management (Excludes OR)	90%									91%	86%	93%
		Non-pharmacologic pain interventions (# of patients)						14	15	11	9	8	14	23
		High Risk Screening task /assessment (MOSS)											744	730
		-Number of 3 or 4											3	1
		Number of patients with Narcan administered		9	5	7	**89**	7	2	13	8	12	9	5
		- Number of Narcan doses administered (All areas)		13	6	14	**139**	10	2	22	9	20	12	14
	OCT 2021	 Reno County data												
	Mar 22	Impact of Overdose – Narcan Training scheduled April 6th (Director Level) 2-4p at Doctor's Park; April 19th (Staff Sessions Level) 9a, 12p, 5:30p at Pavilion												
		Review of Pain Management and Opioid Stewardship Dashboard – the past 12 months of data was available and appended to these minutes.												



Metrics – Focused on January and February 2022	Jan 22	Feb 22
Pain Reassessed at least by next assessment	91%	90%
Effectiveness of pain management (Excludes OR)	91%	86%
Non-pharmacologic pain interventions (# of patients)	24	27
High Risk Screening task /assessment (MOSS)	647	565
-Number of 3 or 4	4	0

Lori and Jessica report that all ortho/joint patients get ice, and PT encourages ice to be moved prior to administering narcotics

Discussion held on administering scheduled pain medications when patients have no pain, or pain rating does not match the pain scale on the medication order.

Reassessment with in 30 or 60 minutes

Compliance with Reassessment	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
SDC/PACU/OR	93%	90%	98%	93%	92%	96%	93%	94%	95%	89%	#DIV/0!	#DIV/0!
ICU	80%	94%	82%	84%	50%	86%	100%	77%	72%	100%	79%	87%
ED	71%	69%	71%	68%	77%	65%	70%	81%	66%	74%	40%	62%
3300 - Ortho & Med/Surg	83%	86%	93%	87%	81%	N/A	81%	83%	73%	74%	#DIV/0!	59%
3400 - BH	N/A	N/A	N/A	N/A	N/A	N/A	64%	N/A	56%	N/A	#DIV/0!	N/A
LDRP	85%	84%	100%	76%	100%	54%	86%	75%	100%	83%	71%	92%
4100 - IPR	67%	83%	90%	33%	61%	96%	95%	89%	89%	41%	44%	#DIV/0!
4200 - Women's & Peds	N/A	N/A	90%	81%	67%	N/A	N/A	100%	N/A	57%	#DIV/0!	N/A
5300/4400 - COVID/Pulm	76%	79%	66%	62%	74%	81%	79%	74%	80%	85%	71%	66%
5100 - Tele	44%	53%	56%	51%	67%	68%	56%	60%	64%	57%	49%	52%
Total Compliance	**78%**	**82%**	**86%**	**79%**	**78%**	**81%**	**81%**	**79%**	**79%**	**74%**	**51%**	**63%**

Reassessment by next assessment

Compliance with Reassessment	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
SDC/PACU/OR	93%	90%	99%	93%	92%	96%	95%	97%	98%	95%	#DIV/0!	#DIV/0!
ICU	98%	98%	91%	89%	100%	94%	100%	93%	83%	100%	88%	92%
ED	83%	81%	89%	86%	94%	92%	94%	92%	90%	94%	90%	94%
3300 - Ortho & Med/Surg	95%	97%	95%	100%	94%	N/A	96%	92%	93%	95%	#DIV/0!	84%
3400 - BH	N/A	N/A	N/A	N/A	N/A	N/A	91%	N/A	100%	N/A	#DIV/0!	N/A
LDRP	92%	84%	100%	82%	100%	58%	90%	75%	100%	83%	71%	92%
4100 - IPR	100%	100%	95%	33%	91%	100%	100%	100%	100%	88%	100%	#DIV/0!
4200 - Women's & Peds	N/A	N/A	90%	81%	100%	N/A	N/A	100%	N/A	86%	#DIV/0!	N/A
5300/4400 - COVID/Pulm	79%	97%	95%	87%	93%	95%	91%	81%	95%	98%	0%	0%
5100 - Tele	92%	94%	84%	86%	92%	95%	97%	95%	95%	93%	94%	92%
Total Compliance	**91%**	**92%**	**95%**	**89%**	**93%**	**94%**	**95%**	**92%**	**94%**	**95%**	**80%**	**75%**

Effectiveness of Pain Management

Percent of pain management that was effective	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
ICU	89%	73%	79%	100%	85%	94%	100%	100%	100%	84%
ED	81%	76%	97%	88%	84%	81%	87%	87%	82%	87%
3300 - Ortho & Med/Surg	90%	87%	95%	N/A	92%	92%	91%	90%	#DIV/0!	84%
3400 - BH	N/A	N/A	N/A	100%	100%	N/A	100%	N/A	#DIV/0!	N/A
LDRP	100%	100%	100%	93%	94%	67%	89%	100%	80%	78%
4100 - IPR	98%	100%	90%	81%	83%	100%	100%	53%	100%	#DIV/0!
4200 - Women's & Peds	100%	100%	100%	N/A	N/A	100%	N/A	80%	N/A	N/A
5300/4400 - COVID/Pulm	88%	87%	87%	94%	86%	94%	100%	73%	79%	80%
5100 - Tele	97%	95%	97%	87%	94%	96%	96%	92%	96%	89%
Total Compliance	91%	86%	93%	89%	90%	91%	92%	87%	**91%**	**86%**

Interventional Radiology Metrics

Interventional Radiology Metrics	MAR 21	APR 21	MAY 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	JAN 22	FEB 22
Number of Procedures	19	26	27	22	12	22	29	29	8	19	19	28
Number of Patients with effective Pain Control	19	26	27	22	12	20	29	29	8	19	19	28
Pain control was effective including biopsy's	100%	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%
						Gave IBU to one patient and Tylenol to another.						

Narcan Administration

Metrics	Target/ Threshold	MAR 21	APR 21	MAY 21	JUNE 21	JULY 21	AUG 21	SEP 21	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22
Number of patients with Narcan administered		13	8	12	9	8	5	12	16	10	5	5	8
- Number of Narcan doses administered (All areas)		22	9	20	12	8	6	15	20	12	6	7	14
- Community Onset (Narcan as a result of OD prior to arrival, both intentional/non-intentional)		19	5	14	12	6	4	11	14	8	3	3	9
- HRMC Related to over sedation (pain meds)		0	1	2	0	1	0	4	4	2	1	0	0
- Moderate Sedation		0	0	1	0	0	0	1	0	0	0	0	0
- Related to Surgery		3	0	2	0	1	1	1	0	2	1	4	5
- Related to Cath Lab		0	1	0	0	0	0	0	1	0	0	0	0
-Treatment plan (tried for unknown unresponsiveness- not effective)		2	3	4	0	0	1	1	4	3	1	4	5
- High risk patients for over sedation		12	6	11	7	5	4	11	15	10	5	4	7
- High risk patients with mitigation applied (EtCO2, pulse oximeter)		11	7	12	7	5	4	10	15	10	5	4	7
Adverse Events related to opioids (RL6)	0	0	2	5	0	0	0	0	0	0	1	0	1

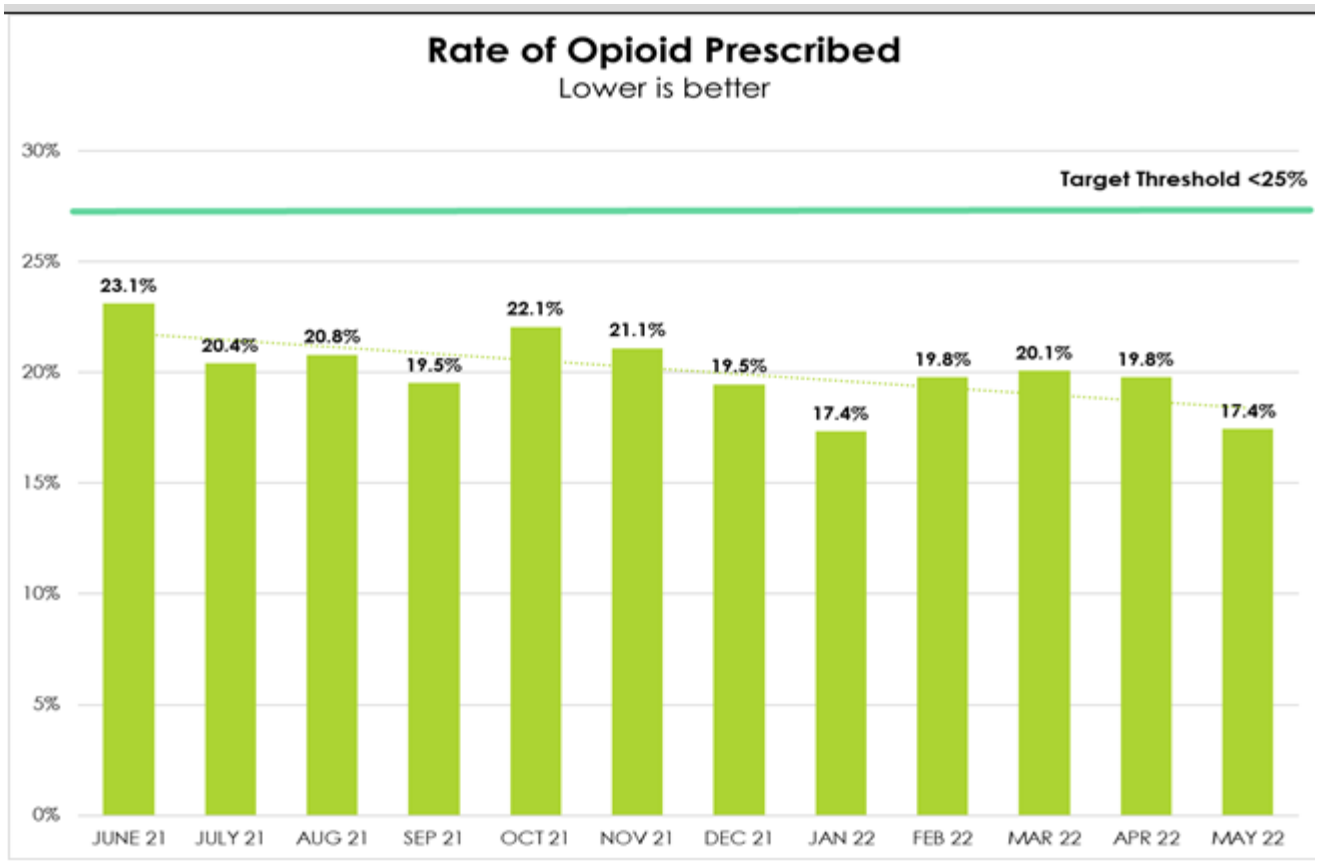
	Dec 21	Jan 22
ODMAP (County Overdose) tracking	12	17
-Non-Fatal	12	17
-Fatal	0	0
-Narcan Administered (1 or more)	1	5
-EMS	0	0
-Fire	0	1
-Police	1	0
-Hospital	0	0
-Bystander	0	3
-Unknown	0	1
-Type of Drug Suspected		
- Heroin	0	1
- Oxycodone	0	2
- Fentanyl	0	1
- Cocaine	0	1
-Prescription Drugs	1	6
- Methamphetamine	5	2
- Benzodiazepine	0	2
- Alcohol	3	5
- LSD	0	0
- OTC	1	2
- Synthetic Marijuana	0	0

		- Other 2 2 -Gender - Male 9 11 - Female 3 6 -Age Range 24-64 17-63 Reno County data is slightly different, and includes Coroner cases.
		
Jun 2022		1. Overview of Ad-Hoc meeting with Recovery Response Team on 6-22-22, a trifold brochure and consent form were supplied. 2. Approval of Discharge Paperwork with Recovery Response Statement "If you or someone you know has experienced a relapse or overdose, whether intentional or unintentional, call the Recovery Response Team at **620-888-6087**. The Recovery Response Team is available to **anyone**, and will connect them with community resources for recovery and

Review of Pain Management and Opioid Stewardship Dashboard – the past 12 months of data was available and appended to these minutes.a. treatment, and other essential services to support individual needs within 24-72 hours. No referral is necessary. For medical emergencies, call **911**. For the Horizons Mental Health Center's 24-Hour Crisis Line, call **800-794-0163**."

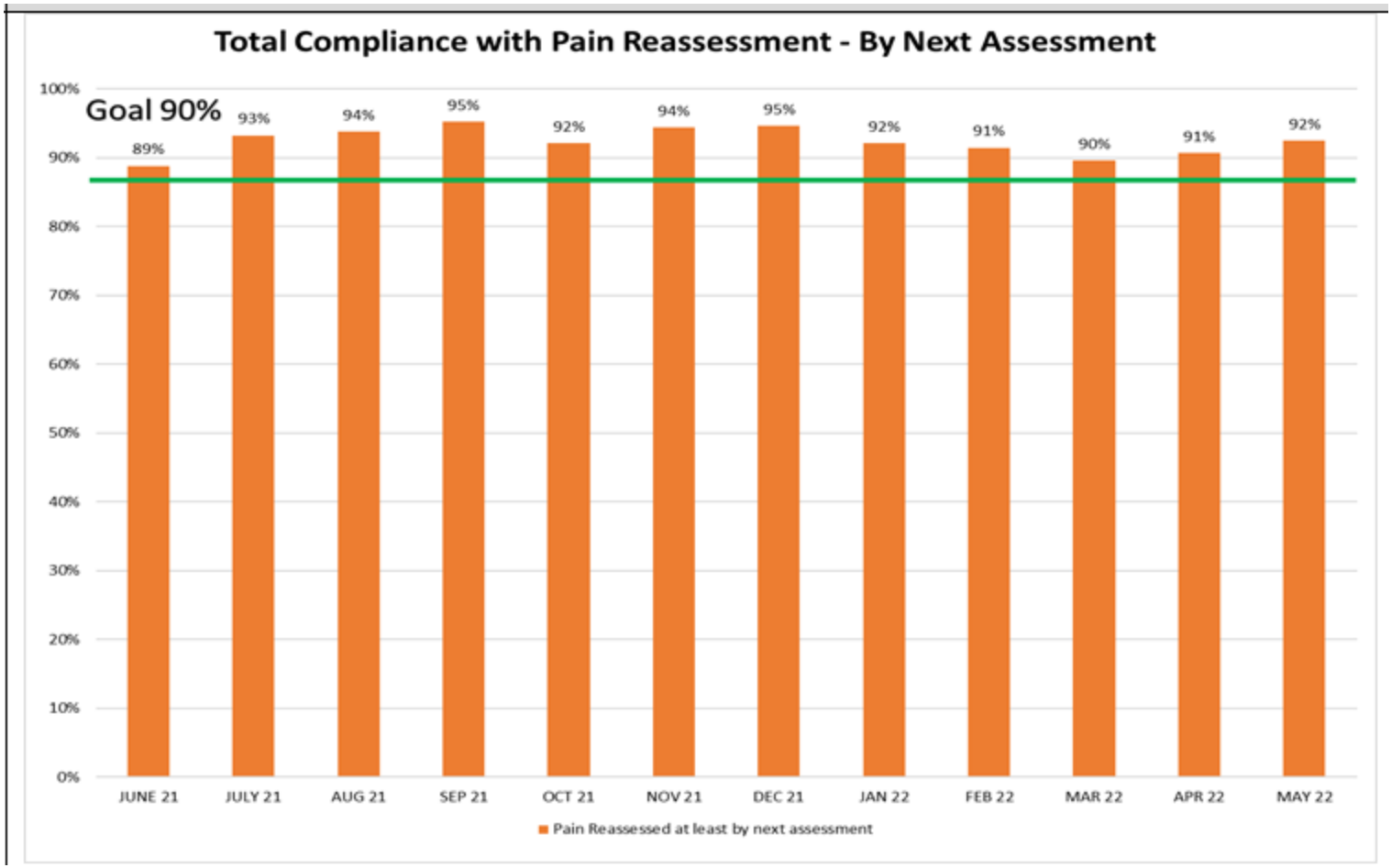
b. Discussion regarding whether to include this in only ED discharges or for all discharges. It was agreed that we would add it to all discharges and place it after diagnosis specific discharge instructions/education. A motion to approve was made and seconded.

Metrics – Focused on March, April, and May 2022	Mar 22	Apr 22	May 22
Pain Reassessed at least by next assessment	90%	91%	92%
Effectiveness of pain management (Excludes OR)	86%	86%	89%
Non-pharmacologic pain interventions (# of patients)	33	24	21
Rate of Opioid Prescribed	20.1%	19.8%	17.4%
-Total Patients in Population	2629	2490	2482
High Risk Screening task /assessment (MOSS)	702	727	711
-Number of 3 or 4	1	1	0
Number of Opioids Administered	3575	2814	3332
Number of Patients Receiving Opioids	595	650	607


Rate of Opioid Prescribed
Lower is better
30%
25%
20%
15%
10%
5%
0%
Target Threshold <25%
23.1%
20.4%
20.8%
19.5%
22.1%
21.1%
19.5%
17.4%
19.8%
20.1%
19.8%
17.4%
JUNE 21
JULY 21
AUG 21
SEP 21
OCT 21
NOV 21
DEC 21
JAN 22
FEB 22
MAR 22
APR 22
MAY 22

Reassessment by next assessment

Compliance with Reassessment (by next assessment)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
SDC/PACU/OR	93%	92%	96%	95%	97%	98%	95%	95%	98%	89%	97%	99%
ICU	89%	100%	94%	100%	93%	83%	100%	88%	92%	89%	86%	91%
ED	86%	94%	92%	94%	92%	90%	94%	90%	94%	95%	91%	92%
3300 - Ortho & Med/Surg	100%	94%	N/A	96%	92%	93%	95%	92%	84%	83%	84%	92%
3400 - BH	N/A	N/A	N/A	91%	N/A	100%	N/A	100%	N/A	N/A	N/A	N/A
LDRP	82%	100%	58%	90%	75%	100%	83%	71%	92%	64%	83%	89%
4100 - IPR	33%	91%	100%	100%	100%	100%	88%	100%	95%	95%	87%	100%
4200 - Women's & Peds	81%	100%	N/A	N/A	100%	N/A	86%	N/A	N/A	N/A	N/A	N/A
5300/4400 - COVID/Pulm	87%	93%	95%	91%	81%	95%	98%	91%	93%	94%	84%	81%
5100 - Tele	86%	92%	95%	97%	95%	95%	93%	94%	92%	91%	96%	95%
Total Compliance	**89%**	**93%**	**94%**	**95%**	**92%**	**94%**	**95%**	**92%**	**91%**	**90%**	**91%**	**92%**


Total Compliance with Pain Reassessment - By Next Assessment
Goal 90%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
89%
93%
94%
95%
92%
94%
95%
92%
91%
90%
91%
92%
JUNE 21
JULY 21
AUG 21
SEP 21
OCT 21
NOV 21
DEC 21
JAN 22
FEB 22
MAR 22
APR 22
MAY 22
Pain Reassessed at least by next assessment

Effectiveness of Pain Management

Percent of pain management that was effective	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
ICU	73%	79%	100%	85%	94%	100%	100%	100%	84%	84%	91%	90%
ED	76%	97%	88%	84%	81%	87%	87%	82%	87%	79%	82%	81%
3300 - Ortho & Med/Surg	87%	95%	N/A	92%	92%	91%	90%	90%	84%	82%	92%	90%
3400 - BH	N/A	N/A	100%	100%	N/A	100%	N/A	67%	N/A	N/A	N/A	N/A
LDRP	100%	100%	93%	94%	67%	89%	100%	80%	78%	100%	80%	71%
4100 - IPR	100%	90%	81%	83%	100%	100%	53%	100%	90%	85%	87%	96%
4200 - Women's & Peds	100%	100%	N/A	N/A	100%	N/A	80%	N/A	N/A	N/A	N/A	N/A
5300/4400 - COVID/Pulm	87%	87%	94%	86%	94%	100%	73%	79%	80%	98%	91%	83%
5100 - Tele	95%	97%	87%	94%	96%	96%	92%	96%	89%	96%	84%	95%
Total Compliance	**86%**	**93%**	**89%**	**90%**	**91%**	**92%**	**87%**	**90%**	**86%**	**86%**	**86%**	**89%**

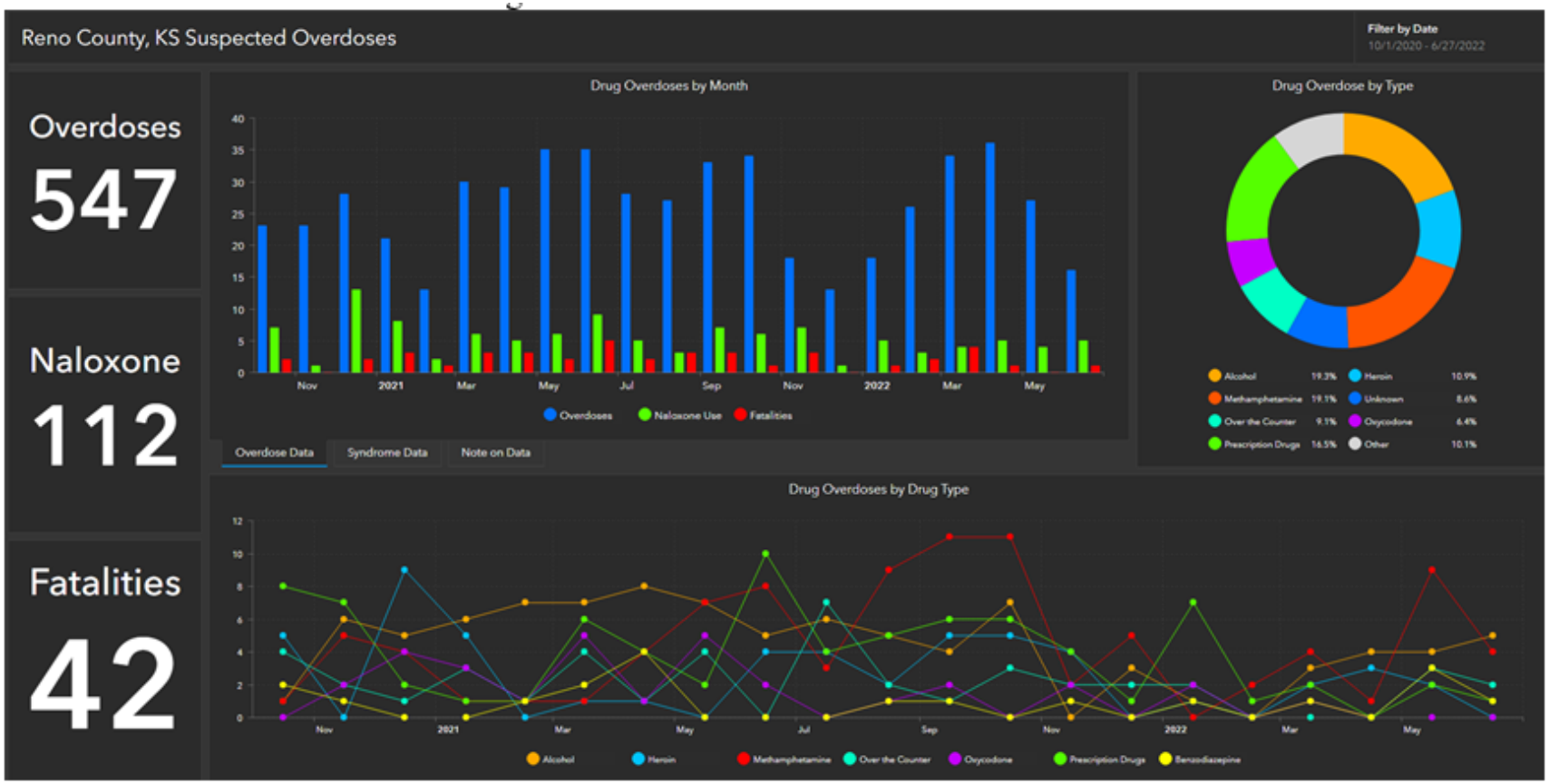
Narcan Administration

Metrics	Target/ Threshold	JUNE 21	JULY 21	AUG 21	SEP 21	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22
Number of patients with Narcan administered		9	8	5	12	16	10	5	5	8	2	8	10
- Number of Narcan doses administered (All areas)		12	8	6	15	20	12	6	7	14	3	10	15
- Community Onset (Narcan as a result of OD prior to arrival, both intentional/non-intentional)		12	6	4	11	14	8	3	3	9	3	9	15
- HRMC Related to over sedation (pain meds)		0	1	0	4	4	2	1	0	0	0	0	0
- Moderate Sedation		0	0	0	1	0	0	0	0	0	0	1	0
- Related to Surgery		0	1	1	1	0	2	1	4	5	0	0	0
- Related to Cath Lab		0	0	0	0	1	0	0	0	0	0	0	0
-Treatment plan (tried for unknown unresponsiveness- not effective)		0	0	1	1	4	3	1	4	5	0	1	0
- High risk patients for over sedation		7	5	4	11	15	10	5	4	7	2	7	4
- High risk patients with mitigation applied (EtCO2, pulse oximeter)		7	5	4	10	15	10	5	4	7	2	7	4
Adverse Events related to opioids (RL6)	0	0	0	0	0	0	0	1	0	0	0	0	0

OD Map

Metrics	Target/ Threshold	JUNE 21	JULY 21	AUG 21	SEP 21	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22
ODMAP (County Overdose) tracking		**30**	**23**	**25**	**28**	**30**	**17**	**12**	**17**		**34**	**36**	**27**
-Non-Fatal		30	23	25	28	30	17	12	17		30	35	27
-Fatal		0	0	0	0	0	0	0	0		4	1	**0**
-Narcan Administered (1 or more)		8	2	3	7	**6**	**7**	**1**	5		4	5	4
-Type of Drug Suspected													
- Heroin		3	2	2	3	5	4	0	1		0	3	2
- Oxycodone		1	0	1	2	0	2	0	2		0	0	0
- Fentanyl		0	0	0	0	1	1	0	1		0	0	2
- Cocaine		0	1	0	0	0	0	0	1		0	0	0
-Prescription Drugs		9	2	4	5	5	4	1	6		2	0	2
- Methamphetamine		4	3	9	10	9	2	5	2		4	1	9
- Benzodiazepine		0	0	1	0	0	1	0	2		1	0	3
- Alcohol		5	6	5	4	6	0	3	5		3	4	4
- LSD		0	0	0	0	0	1	0	0		0	0	0
- OTC		0	6	1	1	3	2	1	2		0	0	3
- Synthetic Marijuana		0	0	0	0	0	0	0	0		0	1	0
- Other		8	3	2	3	1	0	2	2		0	1	2

In April 2022, Reno County Health Department updated the overdose fatality numbers after several fatalities that occurred in 2021 were verified through tox screens.



https://reno.maps.arcgis.com/apps/opsdashboard/index.html#/6e5f01c85f524c08b9aea458926f8fdb

Aug 2022		. Upcoming Education Courses – a. Buprenorphine Certification Course –

Free virtual class by KU Med regarding buprenorphine treatment of opioid use disorder in an office-

based setting. Tuesday, Aug 30th. Registration due by 5pm on Friday, Aug 26th.

https://www.eeds.com/byinviteonly/652877

b. Annual Kansas Prevention Conference –

Held in Wichita by the Kansas Prevention Collaborative on Oct 27-28th, Pre-Conference Oct 26th.

Registration Fee: $150 before Oct 5th, and $175 after Oct 5th

https://kansaspreventioncollaborative.org/conference/

c. Annual Kansas Opioid and Stimulant Conference –

Held in Topeka by DCCA on Nov 10th. Registration opens Sept 15th: $35 fee, after Oct 16th fee

increases to $50. Can be used towards continuing education for CME, CNE, BSRB, EMS, and

Pharmacy

https://www.dccca.org/2022-kansas-opioid-and-stimulant-conference/

. K-Tracks data – Kim and Seth were at the Hospital Quality Collaborative last Friday. The K-Tracks representative Gale, mentioned that we should be able to get delegate access to view the community prescribing rates by practitioner.

- Can now pull provider specific reports
- Drugs of concern: gabapentin, promethazine with codeine, combos of butalbital/acetaminophen/caffeine, prescription ephedrine/pseudoephedrine
- **Not** part of the database: drugs administered to patients (inpatient hospital, methadone clinic, etc.), naloxone, diagnostic information

3. CMS eCQM (electronic clinical quality measure): Safe Use of Opioids – Concurrent Prescribing

a. Data submitted annually to CMS via Cerner

b. Adding to dashboard

c. Numerator: Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge

d. Denominator: Inpatient hospitalizations that end during the measurement period, where the patient is 18 or older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge

e. Exclusions: Inpatient hospitalizations where patients have cancer prior to or during the encounter, receive palliative or hospice care during the encounter, discharge to another inpatient care facility, or who expire during the inpatient stay

RRC Recovery Portal - https://renorecoveryks.com

Seth reviewed the history of RRC and transition from the drug impact taskforce. He reviewed the new portal. He mentioned that there are multiple resources on the portal.

Recovery Response Team will respond in 24-48 hours. Seth encouraged everyone to review the tools. The self-assessment is very important. Other tools include: Depression, Anxiety, Opioid Risk, Cage Adult Alcohol assessment, and CRAFFT adolescent alcohol and substance use. Then they can look for local services. This tool is to help Quick look at our overdose data and what drugs are involved. This is not a scare tactic rather to keep the community informed. Hopeful this tool gets used.

Reported that the detox facility is full. Health department will be launching a billboard campaign to drive to the portal and reducing stigma. Active recovery tab – non-traditional work group. Encourage them to come even if they are actively using. Empowers people

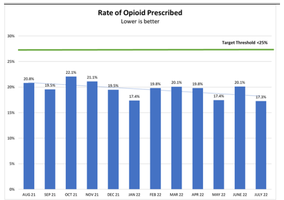
Lori reported that case management is having the patients call the oxford house themselves. Megan reported that the discharge paperwork now has the phone number for the Recovery Response team, and brief information about the team. Plan to put the Recovery Portal link into the discharge paperwork as well.

Jill asked if there were resources for post-partum depression? Seth said no, but could be possible.

Seth mentioned that Reno County is a pioneer in our advocacy and OD map. What is killing people in PA is the benzodiazepines. Discussed use of romazicon. The Appalachian area is number 2 in the nation for increase of OD fatalities. This is the area Reno County looks to see what drug trends will be headed this direction.

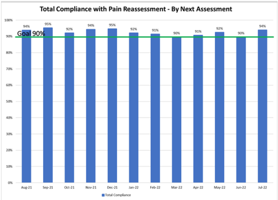
Review of Pain Management and Opioid Stewardship Dashboard – the past 12 months of data was available and appended to these minutes.

Metrics – Focused on June and July 2022	Jun 22	Jul 22
Pain Reassessed at least by next assessment	90%	94%
Effectiveness of pain management (Excludes OR)	90%	86%
Non-pharmacologic pain interventions (# of patients)	20	19
Rate of Opioid Prescribed	20.1%	17.3%
-Total Patients in Population	2551	2707
CMS eCQM: Safe Use of Opioids	9/114	10/109
High Risk Screening task /assessment (MOSS)	746	779
-Number of 3 or 4	3	3
Number of Opioids Administered	3242	3538
Number of Patients Receiving Opioids	639	647



Compliance with Pain Reassessment by Next Assessment:

Compliance with Reassessment (by next assessment)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
SDC/PACU/OR	93%	92%	96%	95%	97%	98%	95%	95%	98%	89%	97%	99%	100%	98%
ICU	89%	100%	94%	100%	93%	83%	100%	88%	92%	89%	86%	91%	94%	94%
ED	86%	94%	92%	94%	92%	90%	94%	90%	94%	95%	91%	92%	91%	96%
3300 - Ortho & Med/Surg	100%	94%	N/A	96%	92%	93%	95%	92%	84%	83%	84%	92%	85%	92%
3400 - BH	N/A	N/A	N/A	91%	N/A	100%	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A
LDRP	82%	100%	58%	90%	75%	100%	83%	71%	92%	64%	83%	89%	89%	80%
4100 - IPR	33%	91%	100%	100%	100%	100%	88%	100%	95%	95%	87%	100%	86%	58%
4200 - Women's & Peds	81%	100%	N/A	N/A	100%	N/A	86%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5300/4400 - COVID/Pulm	87%	93%	95%	91%	81%	95%	98%	91%	93%	94%	84%	81%	92%	93%
5100 - Tele	86%	92%	95%	97%	95%	95%	93%	94%	92%	91%	96%	95%	88%	97%
Total Compliance	**89%**	**93%**	**94%**	**95%**	**92%**	**94%**	**95%**	**92%**	**91%**	**90%**	**91%**	**92%**	**90%**	**94%**



Effectiveness of Pain Management:

Percent of pain management that was effective	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
ICU	73%	79%	100%	85%	94%	100%	100%	100%	84%	84%	91%	90%	96%	91%
ED	76%	97%	88%	84%	81%	87%	87%	82%	87%	79%	82%	81%	79%	75%
3300 - Ortho & Med/Surg	87%	95%	N/A	92%	92%	91%	90%	90%	84%	82%	92%	90%	97%	89%
3400 - BH	N/A	N/A	100%	100%	N/A	100%	N/A	67%	N/A	N/A	N/A	N/A	N/A	N/A
LDRP	100%	100%	93%	94%	67%	89%	100%	80%	78%	100%	80%	71%	100%	100%
4100 - IPR	100%	90%	81%	83%	100%	100%	53%	100%	90%	85%	87%	96%	95%	83%
4200 - Women's & Peds	100%	100%	N/A	N/A	100%	N/A	80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5300/4400 - COVID/Pulm	87%	87%	94%	86%	94%	100%	73%	79%	80%	98%	91%	83%	70%	85%
5100 - Tele	95%	97%	87%	94%	96%	96%	92%	96%	89%	96%	84%	95%	94%	92%
Total Compliance	**86%**	**93%**	**89%**	**90%**	**91%**	**92%**	**87%**	**90%**	**86%**	**86%**	**86%**	**89%**	**90%**	**86%**

Narcan Administration:

Metrics	Target/ Threshold	AUG 21	SEP 21	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22	JUNE 22	JULY 22
Number of patients with Narcan administered		5	12	16	10	5	5	8	2	8	10	7	11
- Number of Narcan doses administered (All areas)		6	15	20	12	6	7	14	3	10	15	8	16
- Community Onset (Narcan as a result of OD prior to arrival, both intentional/non-intentional)		4	11	14	8	3	3	9	3	9	15	6	13
- HRMC Related to over sedation (pain meds)		0	4	4	2	1	0	0	0	0	0	0	3
- Moderate Sedation		0	1	0	0	0	0	0	0	1	0	0	1
- Related to Surgery		1	1	0	2	1	4	5	0	0	0	2	0
- Related to Cath Lab		0	0	1	0	0	0	0	0	0	0	0	0
-Treatment plan (tried for unknown unresponsiveness- not effective)		1	1	4	3	1	4	5	0	1	0	1	1
- High risk patients for over sedation		4	11	15	10	5	4	7	2	7	4	7	10
- High risk patients with mitigation applied (EtCO2, pulse oximeter)		4	10	15	10	5	4	7	2	7	4	7	10

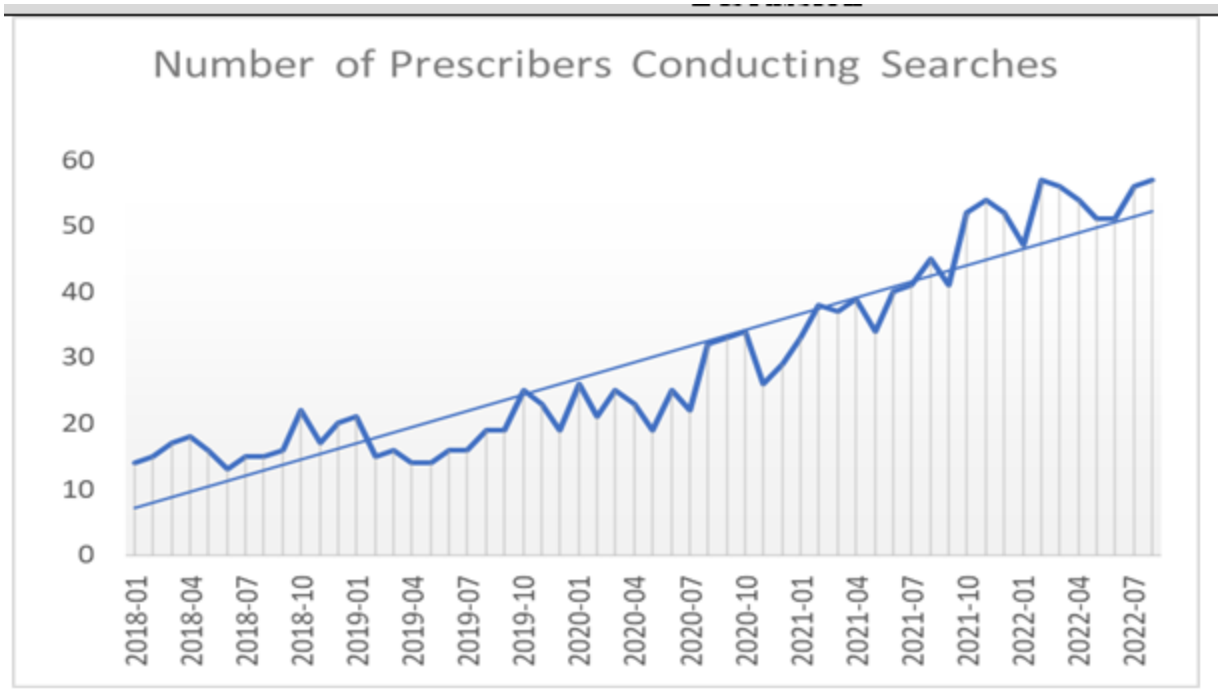
With the high risk for oversedation, we need to look into the MOSS scores. The MOSS should reflect a higher number in the 3-4 score.

OD Map:

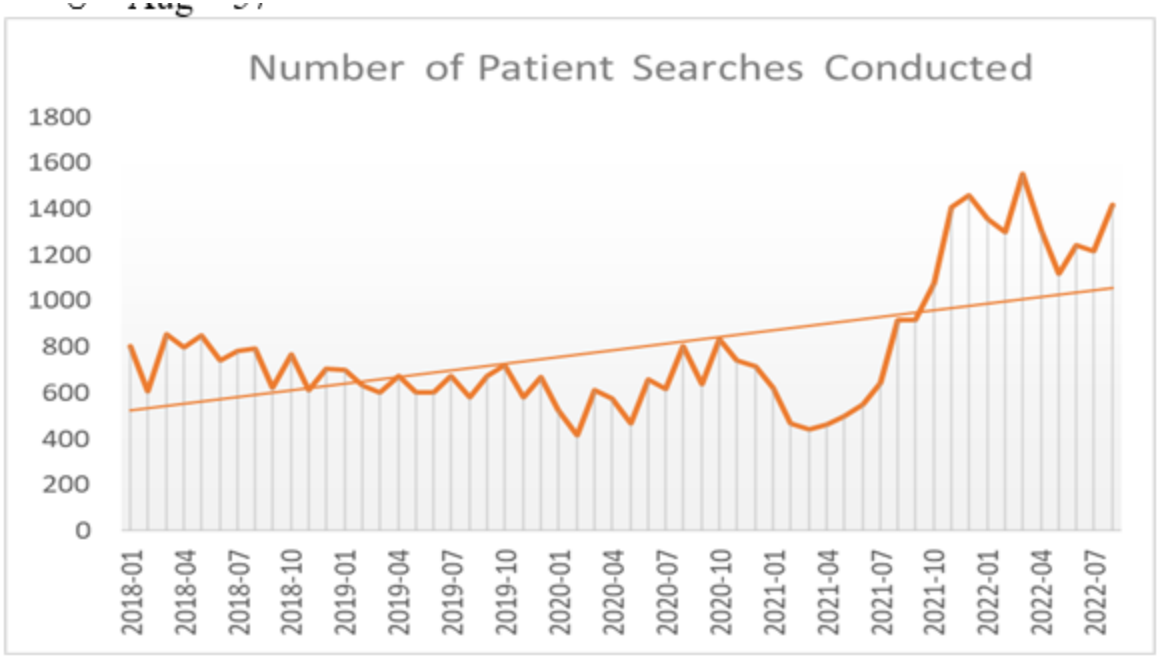
Metrics	AUG 21	SEP 21	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22	JUNE 22	JULY 22
ODMAP (County Overdose) tracking	**25**	**28**	**30**	**17**	**12**	**17**	**ND**	**34**	**36**	**27**	**19**	**16**
-Non-Fatal	25	28	30	17	12	17	ND	30	35	27	18	15
-Fatal	0	0	0	0	0	0	ND	4	1	0	1	1
-Narcan Administered (1 or more)	3	7	6	7	1	5	ND	4	5	4	5	1
-Type of Drug Suspected												
- Heroin	2	3	5	4	0	1	ND	0	3	2	0	1
- Oxycodone	1	2	0	2	0	2	ND	0	0	0	0	0
- Fentanyl	0	0	1	1	0	1	ND	0	0	2	2	1
- Cocaine	0	0	0	0	0	1	ND	0	0	0	0	0
-Prescription Drugs	4	5	5	4	1	6	ND	2	0	2	1	2
- Methamphetamine	9	10	9	2	5	2	ND	4	1	9	5	2
- Benzodiazepine	1	0	0	1	0	2	ND	1	0	3	1	1
- Alcohol	5	4	6	0	3	5	ND	3	4	4	5	4
- LSD	0	0	0	1	0	0	ND	0	0	0	0	0
- OTC	1	1	3	2	1	2	ND	0	0	3	2	2
- Synthetic Marijuana	0	0	0	0	0	0	ND	0	1	0	1	0
- Other	2	3	1	0	2	2	ND	0	1	2	1	1

The fatality in July was reported as Heroin.

Oct 2022		1. QR Code for RRC Recovery Portal 1. I.S. created a QR code for the discharge paperwork that will take patients to the portal when scanned. This went live August 25, 2022. 2. Non-Pharmacological Interventions ad-hoc meeting 1. A meeting was held on September 20, 2022 with nursing directors, quality management, I.S., and nursing staff to discuss improving the documentation workflow for charting non-pharmacological interventions. 2. It was found that the Non-Pharmacological Therapy field was a conditional charting field, and did not appear in the iView assessment chart until selecting "Yes" for Pain Present and selecting a pain scale. Multiple other conditional charting fields also appeared with that selection. Non-Pharmacological Therapy was near the bottom of the list. It doesn't come up if the patient can give a pain rating. IS is working on removing some of the redundant fields. The team determined the best action to improve documentation compliance was to remove the extra charting options, make Non-Pharmacological Therapy a permanent charting field and not conditional, and to also move it into the Caregiver Rounding section in the iView as well. This committee will continue to monitor this metric, and hopes to see an improvement with compliance in the future months.



- 2Q2022
  - Apr – 54
  - May – 51
  - Jun – 51
- 3Q2022
  - Jul – 56
  - Aug – 57

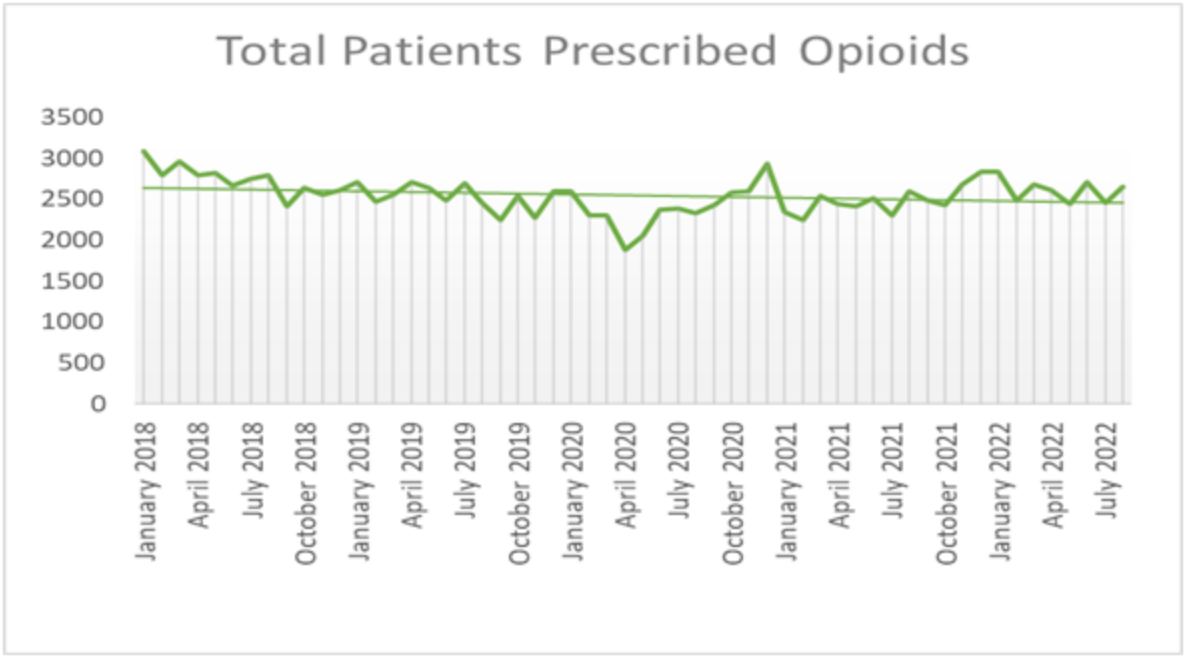


2Q2022

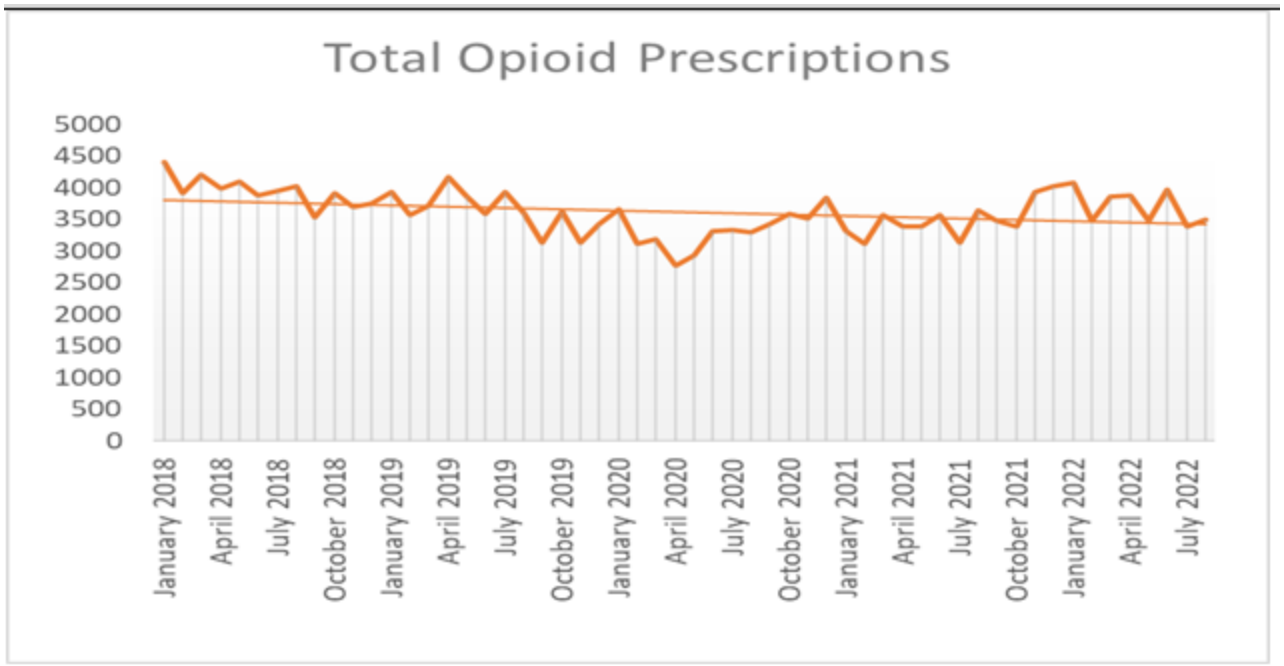
- Apr – 1304
- May – 1119

- Jun – 1241

- 3Q2022
  - Jul – 1219
  - Aug – 1420

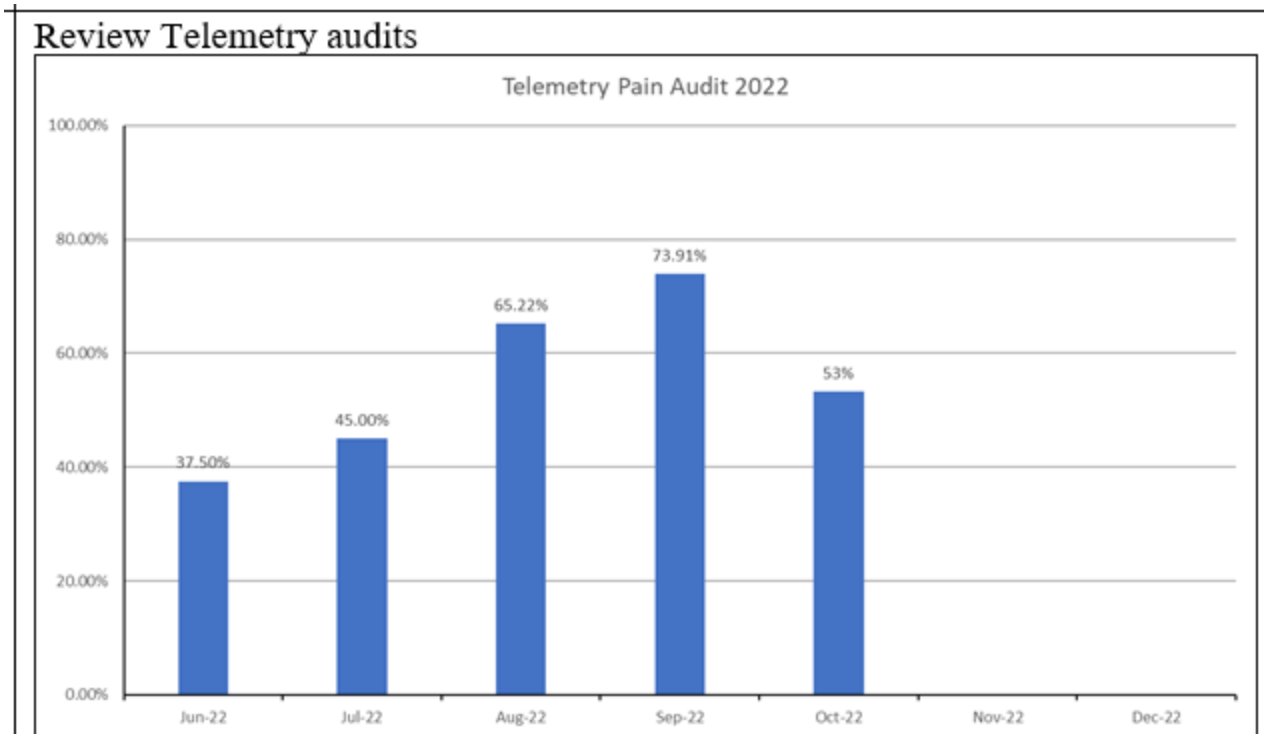


- 2Q2022
  - Apr – 2609
  - May – 2441
  - Jun – 2702
- 3Q2022
  - Jul – 2451
  - Aug – 2653



- 2Q2022
  - Apr – 3884
  - May – 3490
  - Jun – 3977
- 3Q2022
  - Jul – 3885
  - Aug - 3494

Review Telemetry audits



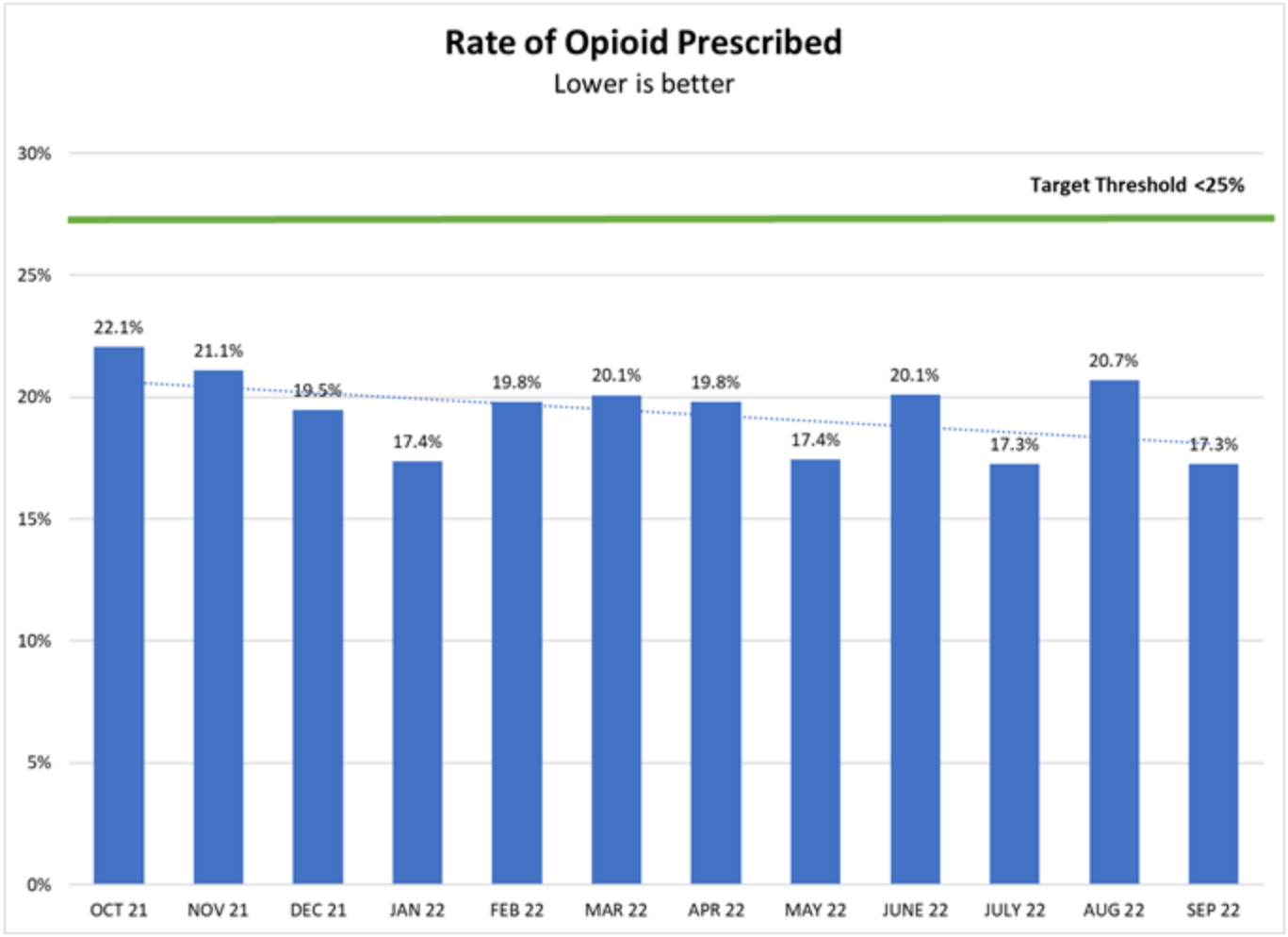
Seth reports an unusual spike in overdoses this month with two fatalities. This is consistent with other counties in our region. This indicates an issue with supplies. They are seeing both fentanyl and heroin.

It's important to understand that when we take patients off their prescribed opiates they often turn to illicit substances. The health department does have a supply of Narcan at this time.

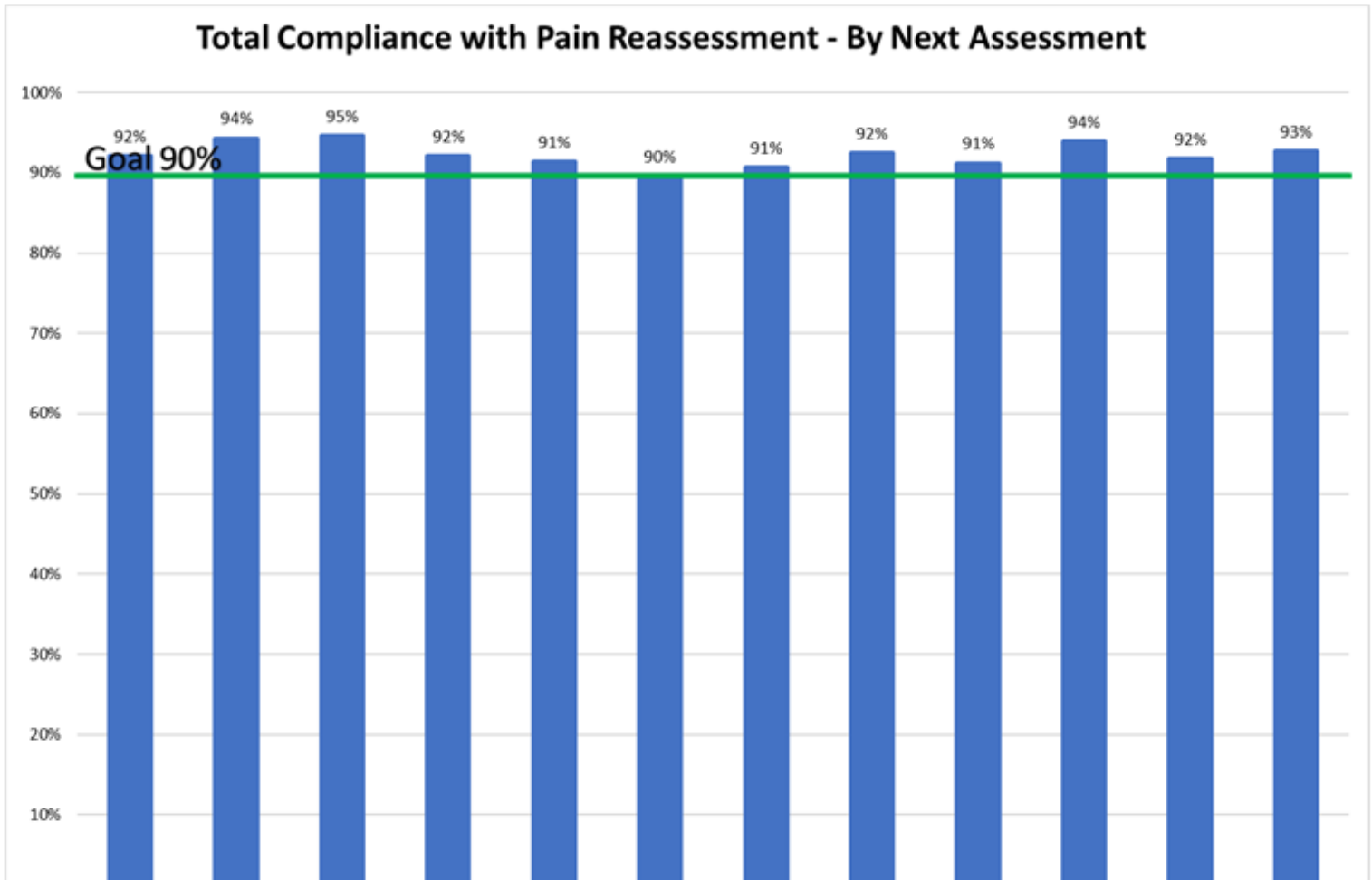
Review of Pain Management and Opioid Stewardship Dashboard

Metrics – Focused on August and September 2022	Aug 22	Sep 22
Pain Reassessed at least by next assessment	92%	93%
Effectiveness of pain management (Excludes OR)	88%	90%
Non-pharmacologic pain interventions (# of patients)	11	18
Rate of Opioid Prescribed	20.7%	17.3%
-Total Patients in Population	2751	2606
CMS eCQM: Safe Use of Opioids	19/117	11/95
	16.2%	11.6%
High Risk Screening task /assessment (MOSS)	752	679
-Number of 3 or 4	3	1

Number of Opioids Administered	3483 3340
Number of Patients Receiving Opioids	663 636



Compliance with Reassessment (by next assessment)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
SDC/PACU/OR	97%	98%	95%	95%	98%	89%	97%	99%	100%	98%	93%	96%
ICU	93%	83%	100%	88%	92%	89%	86%	91%	94%	94%	90%	95%
ED	92%	90%	94%	90%	94%	95%	91%	92%	91%	96%	96%	84%
3300 - Ortho & Med/Surg	92%	93%	95%	92%	84%	83%	84%	92%	92%	93%	N/A	93%
3400 - BH	N/A	100%	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	77%
LDRP	75%	100%	83%	71%	92%	64%	83%	89%	89%	80%	29%	100%
4100 - IPR	100%	100%	88%	100%	95%	95%	87%	100%	86%	58%	76%	100%
4200 - Women's & Peds	100%	N/A	86%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5300/4400 - COVID/Pulm	81%	95%	98%	91%	93%	94%	84%	81%	92%	93%	85%	91%
5100 - Tele	95%	95%	93%	94%	92%	91%	96%	95%	88%	97%	98%	98%
Total Compliance	**92%**	**94%**	**95%**	**92%**	**91%**	**90%**	**91%**	**92%**	**91%**	**94%**	**92%**	**93%**



Percent of pain management that was effective	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
ICU	94%	100%	100%	100%	84%	84%	91%	90%	96%	91%	80%	86%
ED	81%	87%	87%	82%	87%	79%	82%	81%	79%	75%	83%	82%
3300 - Ortho & Med/Surg	92%	91%	90%	90%	84%	82%	92%	90%	89%	88%	86%	93%
3400 - BH	N/A	100%	N/A	67%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	87%
LDRP	67%	89%	100%	80%	78%	100%	80%	71%	100%	100%	0%	0%
4100 - IPR	100%	100%	53%	100%	90%	85%	87%	96%	95%	83%	94%	91%
4200 - Women's & Peds	100%	N/A	80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75%	N/A
5300/4400 - COVID/Pulm	94%	100%	73%	79%	80%	98%	91%	83%	70%	85%	92%	97%
5100 - Tele	96%	96%	92%	96%	89%	96%	84%	95%	94%	92%	97%	90%
Total Compliance	**91%**	**92%**	**87%**	**90%**	**86%**	**86%**	**86%**	**89%**	**89%**	**86%**	**88%**	**90%**

Narcan Administration:

Metrics	Target/ Threshold	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22	JUNE 22	JULY 22	AUG 22	SEP 22
Number of patients with Narcan administered		16	10	5	5	8	2	8	10	7	11	9	2
- Number of Narcan doses administered (All areas)		20	12	6	7	14	3	10	15	8	16	15	3
- Community Onset (Narcan as a result of OD prior to arrival, both intentional/non-intentional)		14	8	3	3	9	3	9	15	6	13	14	3
- HRMC Related to over sedation (pain meds)		4	2	1	0	0	0	0	0	0	3	1	0
- Moderate Sedation		0	0	0	0	0	0	1	0	0	1	0	0
- Related to Surgery		0	2	1	4	5	0	0	0	2	0	0	0
- Related to Cath Lab		1	0	0	0	0	0	0	0	0	0	0	0
-Treatment plan (tried for unknown unresponsiveness- not effective)		4	3	1	4	5	0	1	0	1	1	0	0
- High risk patients for over sedation		15	10	5	4	7	2	7	4	7	10	7	1
- High risk patients with mitigation applied (EtCO2, pulse oximeter)		15	10	5	4	7	2	7	4	7	10	7	1
Adverse Events related to opioids (RL6)	0	0	0	1	0	0	0	0	0	0	1	1	0

A Comparison between patients administered Narcan and MOSS scores as completed for August and September data, based on the concern voiced at the August meeting regarding the high number of high-risk for over sedation patients that received Narcan versus the very low number of patients who score a 3 or 4 on the MOSS assessment. The results are as follows:

	August-	September-	
Total patients with MOSS:	752	679	
MOSS 0-1:	654	590	
MOSS 2:	56	45	
MOSS 3-4:	3	1	
Other:	39	43	The "Other" field was typically documented as "Done," "Duplicate," or "Not Appropriate At This Time."
Total Narcan Patients:	9	2	
Total High Risk:	7	1	
High Risk with MOSS:	5	0	
Narcan Patients with MOSS:	6	0	
MOSS 0-1:	4	0	
MOSS 2:	2	0	
MOSS 3-4:	0	0	

OD Map:

Metrics	Target/ Threshold	OCT 21	NOV 21	DEC 21	JAN 22	FEB 22	MAR 22	APR 22	MAY 22	JUNE 22	JULY 22	AUG 22	SEP 22
ODMAP (County Overdose) tracking		**30**	**17**	**12**	**17**	**ND**	**34**	**36**	**27**	**19**	**16**	**26**	**22**
-Non-Fatal		30	17	12	17	ND	30	35	27	18	15	26	22
-Fatal		0	0	0	0	ND	4	1	0	1	1	0	0
-Narcan Administered (1 or more)		6	7	1	5	ND	4	5	4	5	1	3	3
-Type of Drug Suspected													
- Heroin		5	4	0	1	ND	0	3	2	0	1	0	0
- Oxycodone		0	2	0	2	ND	0	0	0	0	0	0	1
- Fentanyl		1	1	0	1	ND	0	0	2	2	1	0	1
- Cocaine		0	0	0	1	ND	0	0	0	0	0	0	0
-Prescription Drugs		5	4	1	6	ND	2	0	2	1	2	4	1
- Methamphetamine		9	2	5	2	ND	4	1	9	5	2	5	2
- Benzodiazepine		0	1	0	2	ND	1	0	3	1	1	0	0
- Alcohol		6	0	3	5	ND	3	4	4	5	4	12	10
- LSD		0	1	0	0	ND	0	0	0	0	0	0	0
- OTC		3	2	1	2	ND	0	0	3	2	2	0	1
- Synthetic Marijuana		0	0	0	0	ND	0	1	0	1	0	0	0
- Other		1	0	2	2	ND	0	1	2	1	1	3	2

Aubrey: discussed a patient recently in an outpatient area that needed Narcan but didn't have an IV. Working on a process to make Narcan more available. Likely this will be added to the RRT. Need to also consider whether the outpatient areas need education on how to recognize potential overdoses.

Goal 2: Increase awareness of Smoking Cessation opportunities to the residents of Reno County
Objective 2.1: Provide a consistent message on smoking cessation

Strategy	Timeframe	Responsibility	Potential Partners
Strategy 2.1.1: Determine the options for smoking cessation.	April 2020 – March 2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit
Strategy 2.1.2: Develop an education tool for smoking cessation that meets the needs of the Clinical CHIP members	April 2020 – March 2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit
Strategy 2.1.4: Re-survey Clinical CHIP members regarding compliance with providing smoking cessation education to every smoker treated in their facilities	April 2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit

Outcomes & Measures

Process Indicators

- Develop methods to track number of patients with chronic respiratory disease patients hospitalized
- Increase number of patients served through the Clinical CHIP member agencies that received smoking cessation education brochure
- Increase the number of patients referred to the KAN-Quit program

Outcome Indicators

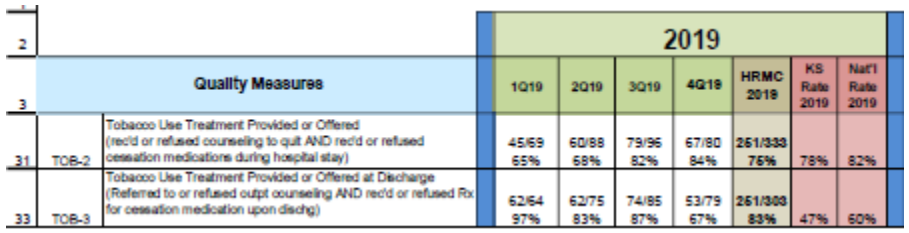
- Increase the % of practitioners that report they provided smoking cessations to the patients they cared for, via survey
- Increase number of patients that complete the KAN-Quit program
- Increase the number of Reno County residents that report they have quit smoking in the last 12 months through the CHNA next survey
- Decrease the number of Reno County residents that report to have smoked a cigarette in the previous 12 months
- Decrease the number of Reno County residents that used an e-cigarette in the previous 12 months.

Metric 2.1	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of RC residents that completed the KAN-Quit program													
# of residents enrolled in the KAN-Quit program													
# of residents that completed the KAN-Quit program													
patients enrolled in the KAN-Quit program at HRMC								1	0	0	1	3	0
# of patients admitted to HRMC that smoke													
# of residents with CRD hospitalized at HRMC													
# KanQuit lung cancer screening interverventions								6	3	2	2	1	2
HRMC in-patients that smoke that received smoking cessation education								23	21	9	31	17	11
% of Hutch Clinic patients that smoke that received smoking cessation education													
% of Prairie Star patients that smoke that received smoking cessation education													

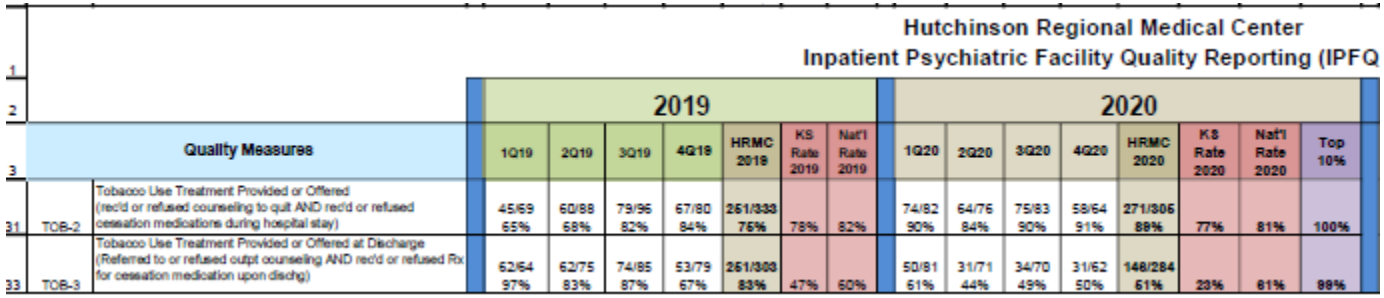
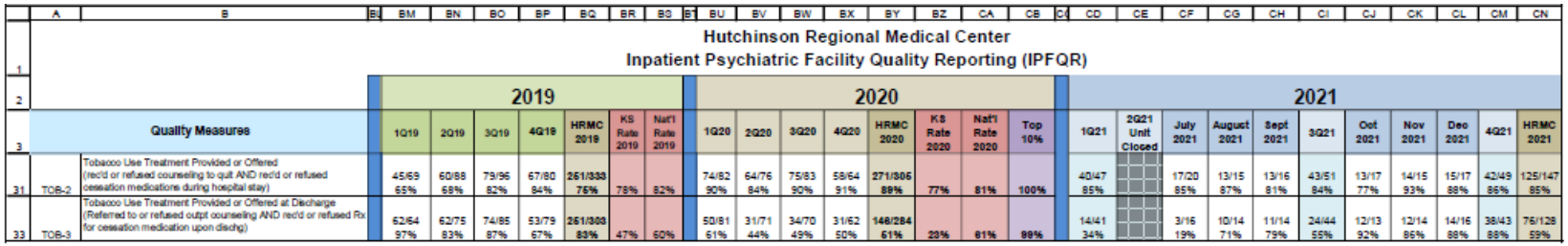
Metric 2.1	Benchmark	Jan 2021	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
% of RC residents that completed the KAN-Quit program													
# of residents enrolled in the KAN-Quit program													
# of residents that completed the KAN-Quit program													
patients enrolled in the KAN-Quit program at HRMC		0	1	0	1	1	1	0	0	0	1	0	1
# of patients admitted to HRMC that smoke													
# of residents with CRD hospitalized at HRMC													
# KanQuit lung cancer screening interverventions		6	5	4	1	3	3	1		1	2	3	2
HRMC in-patients that smoke that received smoking cessation education		16	15	18	9	5	4	3	4	5	2	3	4
% of Hutch Clinic patients that smoke that received smoking cessation education													

% of Prairie Star patients that smoke that received smoking cessation education													

NOTES

Facility	Date	Notes
	Jan 2020	Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 
HRMC	June 2020	Maurice is working on two processes to increase smoking cessation education to patients treated through HRMC. 1)setting up a trigger in Cerner to task the RT of a patient admitted that is a smoker. The RT will then provide smoking cessation and try to get them enrolled in KAN-Quit. 2) when patients arrive for the exam for the Lung Cancer Screening program, and are a smoker, RT will provide smoking cessation and KAN-Quit literature and enroll if agreeable. Issue currently is EMR tasking the RT.
	2019 data	HRMC Stroke patients receiving smoking cessation education 2019 Benchmark Group Time Period Numerator Denominator % of Patients My Hospital 2019 22 22 100.0
	June 2020	Published in the Resident Perception Drive Progress on Health in Reno County that 69% of respondents are aware of community efforts to promote smoking cessation. This compares to the last CHNA question which had 65% that were not aware of smoking cessation programs.
	Aug 2020	PS reported that enrolling in KAN-Quit is part of the EMR that documentation so that they can easily track their information.
		Add smoking cessation education to the Joint Care Class
		Discuss doing a community project for the November Third Thursday – "Great American Smoke Out" November 19
	Sept 2020	3/20 smoking cessation assessments signed up for KanQuit program. Initial discussion on community event on Smoking Cessation for the Great American Smoke Out Day 11/19, possible coordinate with Third Thursday events downtown.
	Nov 2020	Community event was cancelled r/t to COVID. Alternate community action was getting the coffee shops to promote the Great American Smoke Out with coffee cup sleeves and stickers. Respiratory Therapist continue to work with patients on smoking cessation by promoting education and support through the KAN QUIT program. Past month worked with 32 patients and got 2 to sign up for the program
	Jan 2021	61% of HRMC STEMI AMI patients received smoking cessation education for 2020

		Quality Measures	2019 1Q19	2Q19	3Q19	4Q19	HRMC 2019	KS Rate 2019	Nat'l Rate 2019
31	TOB-2	Tobacco Use Treatment Provided or Offered (rec'd or refused counseling to quit AND rec'd or refused cessation medications during hospital stay)	45/69 65%	60/88 68%	79/96 82%	67/80 84%	261/333 78%	78%	82%
33	TOB-3	Tobacco Use Treatment Provided or Offered at Discharge (Referred to or refused outpt counseling AND rec'd or refused Rx for cessation medication upon dischg)	62/64 97%	62/75 83%	74/85 87%	53/79 67%	261/303 86%	47%	60%

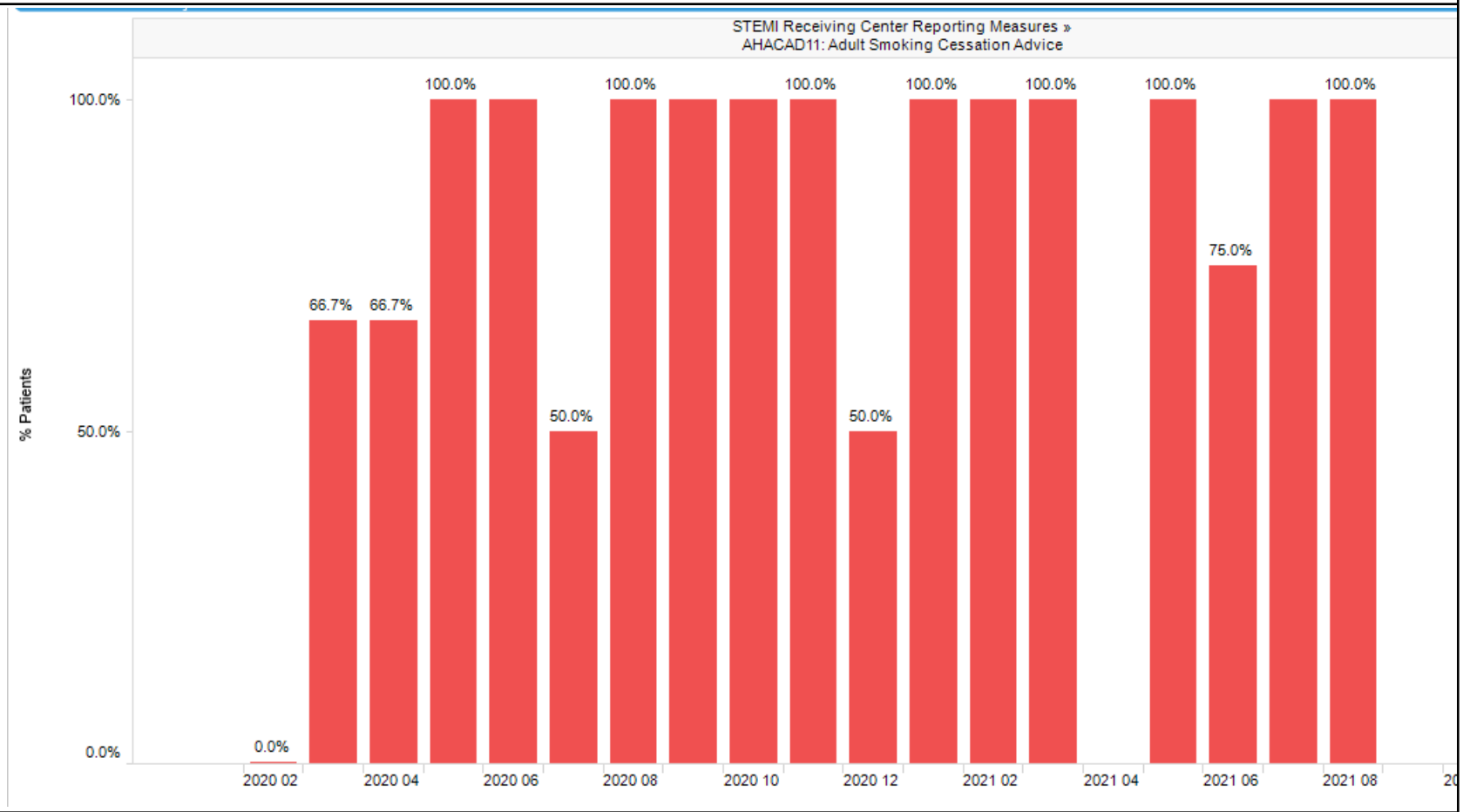
	1/1/2020-6/30/2021	296 patients educated on smoking cessation in cardiac & pulmonary rehab, and ST-elevation myocardial infarction patients
		Created “Tobacco cessation education” documentation in our electronic health record
	Jan 2021	HRMC Stroke patients receiving smoking cessation education 2020 Benchmark Group Time Period Numerator Denominator % of Patients My Hospital 2019 22 22 100.0% My Hospital 2020 15 15 100.0%
		Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 
	4/15/2021	RCHD provided KanQuit Education to HRMC respiratory services for patient referral/education
	5/5/2021	RCHD provided KanQuit Education to HRMC cardiac and pulmonary rehab for patient referral/education
	Dec 2021	85.7% HRMC STEMI AMI patients received smoking cessation education for 2021 (an increase of 24.7%) according to AHA-GWTG CAD data
	Jan 2022	Metrics for smoking cessation and treatment offered to HRMC Behavior Health Unit 2019 

Hutchinson Regional Medical Center
Inpatient Psychiatric Facility Quality Reporting (IPFQ

		Quality Measures	2019 1Q19	2Q19	3Q19	4Q19	HRMC 2019	KS Rate 2019	Nat'l Rate 2019	2020 1Q20	2Q20	3Q20	4Q20	HRMC 2020	KS Rate 2020	Nat'l Rate 2020	Top 10%
31	TOB-2	Tobacco Use Treatment Provided or Offered (rec'd or refused counseling to quit AND rec'd or refused cessation medications during hospital stay)	45/69 65%	60/88 68%	79/96 82%	67/80 84%	251/333 75%	78%	82%	74/82 90%	64/76 84%	75/83 90%	58/64 91%	271/305 88%	77%	81%	100%
33	TOB-3	Tobacco Use Treatment Provided or Offered at Discharge (Referred to or refused outpt counseling AND rec'd or refused Rx for cessation medication upon dischg)	62/64 97%	62/75 83%	74/85 87%	53/79 67%	251/303 83%	47%	60%	50/81 61%	31/71 44%	34/70 49%	31/62 50%	148/284 61%	23%	61%	99%

Hutchinson Regional Medical Center
Inpatient Psychiatric Facility Quality Reporting (IPFQR)

		Quality Measures	2019 1Q19	2Q19	3Q19	4Q19	HRMC 2019	KS Rate 2019	Nat'l Rate 2019	2020 1Q20	2Q20	3Q20	4Q20	HRMC 2020	KS Rate 2020	Nat'l Rate 2020	Top 10%	2021 1Q21	2Q21 Unit Closed	July 2021	August 2021	Sept 2021	3Q21	Oct 2021	Nov 2021	Dec 2021	4Q21	HRMC 2021
31	TOB-2	Tobacco Use Treatment Provided or Offered (rec'd or refused counseling to quit AND rec'd or refused cessation medications during hospital stay)	45/69 65%	60/88 68%	79/96 82%	67/80 84%	251/333 75%	78%	82%	74/82 90%	64/76 84%	75/83 90%	58/64 91%	271/305 88%	77%	81%	100%	40/47 85%		17/20 85%	13/15 87%	13/16 81%	43/51 84%	13/17 77%	14/15 93%	15/17 88%	42/49 86%	125/147 85%
33	TOB-3	Tobacco Use Treatment Provided or Offered at Discharge (Referred to or refused outpt counseling AND rec'd or refused Rx for cessation medication upon dischg)	62/64 97%	62/75 83%	74/85 87%	53/79 67%	251/303 83%	47%	60%	50/81 61%	31/71 44%	34/70 49%	31/62 50%	148/284 61%	23%	61%	99%	14/41 34%		3/16 19%	10/14 71%	11/14 79%	24/44 55%	12/13 92%	12/14 86%	14/16 88%	38/43 88%	76/128 59%



Jan 2022

HRMC Stroke patients receiving smoking cessation education 2021

Benchmark Group	Time Period	Numerator	Denominator	% of Patients
My Hospital	2019	22	22	100.0%
My Hospital	2020	15	15	100.0%
My Hospital	2021	19	19	100.0%

Date of report: 03/24/2022 14:28:48 GMT-05:00 run by User: Julie Wiens (jwiens01) at Site: Hutchinson Regional Medical Center (75886)

Objective 2.2: Increase attendance at smoking cessation classes for residents of Reno County			
Strategy	Timeframe	Responsibility	Potential Partners
Strategy 2.2.1: Review the KAN-Quit program and other smoking cessation classes offered in Reno County	March 2020 – September 2020	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit
Strategy 2.2.3: Conduct pilot KAN-Quit classes using employee groups from Clinical CHIP members	March 2020 - December 2020	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit RCHD
Strategy 2.2.4: Conduct four KAN-Quit classes in different areas of Reno County	2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit RCHD

Outcomes & Measures
Process Indicators
● Increase opportunities for smoking cessations classes in Reno County ● Increase opportunities for businesses to support their employees in smoking cessation
Outcome Indicators
● Decrease the # of people reported to have smoked a cigarette in the previous 12 months ● Decrease the # of people reported to have used an e-cigarette in the previous 12 months

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Metric 2.2	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Same as 2.1													

NOTES

Facility	Date	Notes
HRMC/RCHD	Nov 2020	Group sessions have been put on hold r/t to group meeting restrictions.

Objective 2.3: Develop a program that provides smoking cessation medication free or reduced cost to low income / marginally insured residents of Reno County			
Strategy	Timeframe	Responsibility	Potential Partners
Strategy 2.3.1: Research grants for program	March 2020 – April 2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit
Strategy 2.3.2: Develop a program utilizing smoking cessation classes supplemented by the use of medication	2021	Clinical CHIP members	KAN-Quit RCHD HRHS Hutch Clinic Prairie Star Summit

Outcomes & Measures
Process Indicators
● Increase number of grants applied for ● Increase the dollars received from grants and fundraising to establish program assisting with tobacco cessation ● Increase the number prescriptions for tobacco cessation
Outcome Indicators
● Provide optimal smoking cessation techniques to citizens of Reno County ● Decrease the # of people reported to have smoked a cigarette in the previous 12 months ● Decrease the # of people reported to have used an e-cigarette in the previous 12 months ●

Metric 2.3	Benchmark	Jan 2020	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

NOTES

Facility	Date	Notes
HRMC		Aubrey Nuss has spoke with a couple grant writers, and struggling to find grants that meet compliance criteria. HRMCs insurance meets ACA requirements and offers their employees tobacco cessation medications/aides.