



# Success Stories

**Healthier patients. Lower health costs. Better healthcare.**

How Primaris works with patients and providers to make it happen.

Integrate Care for Populations and Communities

Improve Health for Populations and Communities

Beneficiary and Family-Centered Care

Improve Individual Patient Care



# Introduction

In August 2011, the Centers for Medicare and Medicare Services outlined a new set of projects for Quality Improvement Organizations (QIOs) to tackle. The projects, which run through July 2014, are designed to improve care in America's nursing homes, physician offices, hospitals and other care settings, focusing on a patient-centered approach.

CMS's projects center around four major goals:

- Improving Individual Patient Care
- Integrating Care for Populations and Communities
- Improving Health for Populations and Communities
- Beneficiary- and Family-Centered Care

The Improving Individual Patient Care aim includes goals such as reducing healthcare acquired conditions in hospitals and nursing homes, reducing adverse drug events in the community and encouraging hospitals to collect and report accurate data.

Integrating Care for Populations and Communities focuses on reducing avoidable readmissions to hospitals using evidence-based interventions and sustainable solutions through a community-based approach.

The goals to Improve Health for Populations and Communities include increasing rates of preventative screenings, reducing cardiac risk factors, supporting more and better clinical quality data, and connecting electronic health records (EHRs) to quality improvement.

Beneficiary and Family Centered Care emphasizes empowering beneficiaries and families to be more engaged in health care decisions, as well as contributing to safer more effective care as a result of quality improvement work with health care providers.

As Missouri's designated QIO for more than 30 years, Primaris helps our state's hospitals, nursing homes, physicians and other care providers achieve these goals every day. The following pages profile our stories of success in each of the areas listed above.



# Integrate Care for Populations and Communities

Bring together hospitals, nursing homes, patient advocacy organizations and other stakeholders in community coalitions.

Build capacity for improving care transitions.

Improve care transition processes and reduce avoidable 30 day readmissions.

# Sixty Days in the SHOP

## The Stay Healthy Clinic

For many patients, it can be tough to get an appointment on their already packed primary care physician's schedule. Enter the Stay Healthy Clinic, founded in Sept. 2011. The Stay Healthy Clinic sees patients most likely to return to the hospital.

"The primary care physician is where things need to happen," said Elliott. "Patients need a large amount of education and medication review."

Each visit at the Stay Health Clinic is at least 40 minutes in length as a doctor or nurse practitioner goes over every question, condition and medication the patient has – not just the ones they were in the hospital for.

In November 2012, the Stay Health Clinic became a primary care clinic as well. Patients without primary care physicians are now able to make the clinic their regular provider.

## The Breakthrough

By working so closely with patients most likely to come back to the hospital, the SHOP made a huge discovery: 80% of all SHOP patients are somewhat cognitively impaired. Elliott and her colleagues in the program were going in with an expectation of low health literacy before they realized cognitive impairment was the real barrier.

"We were beating our heads against the wall wondering why the patient wouldn't follow the treatment plan or take their medicine," said Elliott. "With cognitive impairment, it's not will; it's inability. It changes your whole mindset when you're caring for the patient."

The breakthrough came in collaboration with Dr. Stanley Birge, a gerontologist at Washington University in St. Louis. His students tested the patients enrolled in the SHOP program before they went home.

"It's been an unbelievable collaboration giving us a whole new trajectory for what we're choosing to do with the patients and interventions to keep them out of the hospital," said Elliott.

The cognitive impairment makes it hard for patients to follow a treatment plan because they don't understand it. Knowing that this cognitive impairment exists let the SHOP turn to family members or caregivers to get involved in the care.

## Keeping patients out of the hospital

There is a case manager on call 24 hours a day, 7 days a week. The patients are encouraged to call anytime, especially if they are feeling poorly and think they need to go to ER. The case manager consults with a nurse practitioner to see if the patient's symptoms warrant an ER visit, treatment over the phone or if the patient could be seen in the Stay Healthy Clinic.

The SHOP also has access to the ER computer program. If a patient comes to the ER, the case managers can see what tests show. The case manager calls the ER doctor to talk about the patient and see what can be done to prevent the patient from being admitted to the hospital again.

"We have been able to avoid readmissions because we interact with the doctors and help assess the condition and follow-up," said Elliott. "It's a great collaboration between all the arms of the program. Everything is for the sake of the patient; everything is for the sake of the program."

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# Hospital Collaborates with Nursing Homes to Improve Community Care Transitions

Miscommunication across settings of care happens every day. And it opens the door for medical errors and missed opportunities.

One Missouri hospital is working to do something about the challenge of communicating effectively during transitions of care. This hospital led the effort to collaborate with area nursing homes to develop solutions to improve continuity of care.

After a hospitalization, Joe White\* was sent to a nursing home for follow-up care. The wrong discharge instructions and incomplete information was provided to the nursing home regarding his follow-up care. Within a week, White had to be readmitted to the hospital.

Primaris review of the case revealed this hospital had a larger systems/Electronic Health Records (EHR) issue related to discharge instructions. When White was transferred to the nursing home, the nursing home was not given the appropriate transfer form that contained information they needed to continue his care.

It's easy to see why the nursing home needs clear, accurate and complete information from the hospital to continue appropriate care for the resident. The hospital was sending a subset of the patient's records, but the nursing home didn't have the time to look through a mountain of records to figure out the basic information needed to care for the patient.

Primaris provided the hospital with sample transfer forms and encouraged the hospital to collaborate with area nursing homes. The hospital pulled together a team of EHR specialists, case management leaders, nursing leadership, physician leadership and nursing home liaisons to discuss needs during the transition of care.

As a result of this open discussion and Primaris' input, the hospital developed a transfer form that included a snapshot of necessary continuity of care information, including diagnoses, medications and allergies. The hospital developed the form with the goals of improving quality, safety, and continuity of patient care during care transitions and to assist with handoff communication and transfer of patient information.

This hospital's efforts to provide clear, concise, accurate transfer information focusing on the patient's current diagnoses and treatment as well as necessary follow-up evaluation and treatment has expedited successful, seamless transitions of care that will have a lasting impact on this community.

\*Not his real name, Medicare protects the privacy of its beneficiaries.

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# Kansas City Care Transitions Community Reduces 30 Day Readmissions

Kansas City has seen early-stage success in its community care transitions program designed to reduce avoidable 30 day readmissions in acute care hospitals. Almost one in five patients are readmitted to the hospital following a discharge within 30 days, costing taxpayers and the government over \$26 billion.

The Kansas City community uses counselors, called care coaches, to encourage patients to seek care from their primary care physicians (PCPs) instead of going to the emergency room.

“The coach’s role is to educate the patient to empower and give them skills they can eventually use to advocate for themselves,” Director of Care Transitions for KCQIC Trent DeVreugd said.

The Kansas City community follows the Coleman Transition Intervention Model, which has a four-pillar approach. The patient should:

1. Be knowledgeable about the medications they are taking
2. Understand and use a Personal Health Record (PHR)
3. Schedule and complete follow-up visits with PCP; and
4. Know red flags their conditions is worsening, and the appropriate action to take.

Care coaches set up three meetings with the patient, starting while the patient is in the hospital. After discharge, the coach sets up a second meeting in the patient’s home where they set

personal goals, review medication instructions, and set up a physician appointment. The coach follows up with the patient once a week for the next 30 days to help with problems that may arise.

“The coach acts as a conduit to help communication between the hospital, patient and primary care physician,” DeVreugd said. “Having that support—someone for the patient to listen to, someone to reinforce or clarify discharge instructions—gives the patients confidence.”

Primaris and the Kansas Foundation for Medical Care, the Medicare Quality Improvement Organizations for Missouri and Kansas, have partnered with KCQIC to create a community of 15 hospitals and more than 30 downstream providers in the Kansas City metro area.

“Primaris has been a major player with us,” DeVreugd said. “They really helped pull the hospitals together and have been a great support from strategic, operational and relationship points of view.”

So far both hospitals and the care coaches are seeing many benefits to the program.

“Hospitals appreciate that we’re working with their patients outside of the hospital and the communication loop it’s creating,” DeVreugd said. “The coaches enjoy working with the patients, especially when the light bulb goes on and are able to advocate for themselves.”

The community’s current goal is to reduce all Medicare fee for service readmissions by 20 percent.

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# Improve Health for Populations and Communities

Use Electronic Health Records (EHRs) to improve preventative care.

Reduce cardiac risk factors.

Integrate health information technology into clinical practice.

# EHR Report Prompts Improvement in Vaccination and Smoking Cessation

When Midwest Chest Consultants in St. Charles pulled their first monthly report for PQRS reporting from their Electronic Health Records (EHR), they immediately began to identify problems related to vaccination and smoking cessation.

“Our documentation for vaccinations was lacking,” said Jill Fritz, nurse practitioner at Midwest Chest Consultants. “I requested the staff ask EVERY patient if they have been vaccinated or would like to be vaccinated.”

Medical assistants are now asking patients if they have received or would like to receive their flu and/or pneumonia vaccination prior to the physician coming in. Then the physician or medical assistant documents this in the system.

In addition, Midwest Chest Consultants partners with a hospital where some patients may choose to get vaccinated instead. Fritz worked with the hospital to get a list of their patients that had received their vaccinations and updated their records to reflect this.

While no results are available yet for flu, pneumonia immunizations have improved from 38 percent to 58 percent.

Smoking cessation was more problematic. Midwest Chest Consultants knew they were doing smoking cessation screening but because it was not being documented correctly, they had no records to show how often. As a result, smoking cessation screening was at zero percent. Fritz loaded a new template into the program to capture the correct information. Within a month, smoking cessation screening went from zero to 100 percent.

“We have been able to streamline our processes and ensure we have accurate documentation,” said Fritz. “This is such a great learning experience, and I look forward to improving our patient care.”

Midwest Chest Consulting is working with Primaris as part of the PQRS EHR-based reporting initiative. Sandy Pogones, program manager for Primaris prompted the first exercise and said, “Their analysis and problem-solving reach the core of what quality improvement is about.”

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# Primaris' Work with National Vendor has National Impact

Primaris work with an EHR vendor has national impact for physician offices. Primaris has worked with the electronic health records (EHR) vendor to address issues providers are facing in regards to using their EHR for quality reporting.

Primaris worked with the vendor to ensure the right provider was being pulled. Both PQRS and meaningful use reports were pulling the primary care physician, not the provider the patient saw. As a result, nurse practitioners and physician assistants weren't showing any patients and none of the providers would have met the 80 percent threshold required for PQRS.

Primaris also worked with the vendor to allow preventive measures to be linked to a flow sheet to document a mammogram or colonoscopy had been performed in the past without having to do a new order.

When the vendor made the flow sheet fix, they also developed a PQRS dashboard that would show all measures in one sheet for a physician with numerators and denominators.

Allowing the providers to see their numbers and where improvements need to be made will have a far-reaching, lasting quality improvement effect.

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# Clinic Forms Quality Committee, Increases Meaningful Use of EHRs

Electronic health records, or EHRs can streamline patient care, yet some physicians are slow to adopt use. Hannibal Clinic in Hannibal, Mo., has been working with Primaris to help physicians use EHRs in a meaningful way that will result in improved patient care.

The clinic formed a quality committee to better utilize EHRs, improve patient care, and achieve meaningful use (complete and accurate information, better access to information and patient empowerment) of EHRs. Providers earn financial incentives by meeting meaningful use criteria.

The committee includes seven physicians from various specialty areas, the administrator, the director of nursing and the director of clinical services. The team worked to develop policies and procedures to direct the quality of patient care in a way that would better utilize EHRs.

The first step was to revamp health reminders, a set of prompts in the EHR system that tells care providers when certain general wellness checks need to be completed.

"We wanted our reminders to be accurate as well as helpful for our providers and beneficial to our patients," Director of Nursing Melody Reynolds said.

Next, the Quality Committee established clinic-wide protocols for blood pressure and diabetes management. All providers regardless of specialty are checking patients' blood pressure and rechecking it at the end of each visit. If the second check is still elevated, the patient makes an appointment with their primary care physician.

The diabetes management protocol requires all diabetic patients have necessary tests documented in the clinic's records. If the patient has not had the tests, the doctor must order them.

Each quarter, the committee reviews every clinic physician's scorecard and identifies physicians requiring more training. The clinic offers a financial incentive to providers for improving scores.

It was a challenge for Hannibal Clinic to get all 60 physicians to learn a new way of reporting patient conditions as well as knowing where information is located in the system, but they've made tremendous progress.

"We've learned that if you take it in slow pieces and provide a lot of one-on-one physician instruction, it seems like it's a little more tolerable for them," Reynolds said.

Although the clinic has been using EHRs since 2008, now, with Primaris' help, Reynolds says they are inching closer to complete implementation to better serve their more than 15,000 patients.

"Primaris is wonderful about sharing their information and forms they've created and they provide good feedback as to where you are with your progress," Reynolds said. "We really appreciate it."

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# Beneficiary and Family-Centered Care

Empower beneficiaries and families to be more engaged in health care decision making.

Contribute to safer, more effective care through quality improvement with providers.

Provide a streamlined process for making and reviewing quality-of-care complaints.

# Nursing Home Implements Therapy Evaluation to Help Reduce Falls

Falls among nursing home residents occur frequently and repeatedly. About 1,800 nursing home residents die each year from fall-related injuries and those who survive falls frequently sustain fractures and other serious injuries.

When Primaris worked with a Missouri nursing home on a case identified from a fall, it was uncertain what the nursing home's response would be to their recommendations for improvements. Primaris was thrilled to encounter a home – and an administrator – that was eager to put processes in place to prevent falls.

Primaris provided the home with a Quality Improvement Plan grid and urged them to do a root-cause analysis of the resident fall. The administrator with the help of the director of nursing and other nursing home staff completed the entire Quality Improvement Plan (QIP), a six-step process including:

- Acknowledgement of issue(s) addressed
- Underlying causes
- Specific cause
- Process improvement actions – what, why, how and when
- Monitoring and evaluating the QIP
- Sustainment

As a result of this process, nursing staff took action. Residents who experience a fall are sent to physical therapy for evaluation and interventions are identified and added to the resident plan of care to prevent future falls.

In addition, the home has taken ownership of the QIP grid and will be using it for all future incidents.

“It [the QIP] made it easier for me to be able to look at the factors and see where the facility was lacking in certain areas,” said the nursing home administrator. “We are using this exercise as a learning tool and applying the steps in the QIP.”

To facilitate future spread of the best practices, Primaris recommended the home share the QIP grid with their corporate system.

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# Family Uses Primaris Resources to Cope with Dementia

When Julie Manuele's mother quit her church choir only days into rehearsals for the annual Christmas program, Manuele knew something was wrong. In addition to her mom's inability to read her choir sheet music, she had been having trouble coming up with words in conversation and she began repeating tasks over and over. Her mother was formally diagnosed with dementia four years ago.

After her mom's diagnosis, Manuele and her family made several big life changes in order to simplify her mom's daily routine. Manuele's parents downsized from a three-story house to a smaller apartment while she was still familiar with her surroundings. They removed anything from the house that could present a tripping hazard and her mom stopped driving.

"The key is to find ways to make things simple and consistent," Manuele said.

Another step Manuele's family took to help her mom relax was to get a safe in which to put all of her jewelry and other valuables. Manuele's mom had been misplacing her jewelry and then forgetting where she put it, so it seemed to her like someone was coming into their home and stealing it.

"It gives her a sense of security," Manuele said. "We're trying to take steps to solve the problems inside her head. It helps her let the anxiety go."

Manuele's father, a retired internal medicine physician, is the primary caretaker at this point. Manuele and her siblings have offered to come help their dad or have someone come in to help,

but so far, he has insisted on having no outside assistance and wants to keep her at home until the end.

"They have a good marriage, so he's enjoying taking care of her," Manuele said. "We're all on the sidelines ready for whenever a transition comes."

Though Manuele's dad cares for her mom most of the time, the disease has taken its toll on the rest of the family as well.

"Emotionally, it's been hard seeing my mom disappear," Manuele said. "She's been one of my best friends for a long time. Not being able to talk to her about deeper issues or confide in her when I'm having problems is hard. Anything distressing upsets her, so we just talk about pleasant things."

In addition to reading information online and books about dementia, and talking with a neurologist, Manuele and her family have found networking with other families going through similar situations to be very effective. Manuele also learned about the webinars Primaris hosts over Labor Day and has been listening to them on a regular basis.

"When I told my dad it was happening to other people too, you could see the tension bleed out of him," she said.

For now, the family is trying to make the most of the time they have left together.

"I heard a great quote on NPR radio: 'You can't ever recover what you've lost but you can embrace what you have now,'" Manuele said. "We're all really trying to adopt that with Mom."

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# Primaris' Advocacy Gets Results

Waiting for results of medical tests can seem like an eternity. When those test results aren't promptly delivered to you, it's easy to see how frustrations and worry would bubble over.

Primaris was contacted by a Medicare beneficiary's daughter for help obtaining her father's medical records. The primary care physician referred her father to a specialist due to an abnormal finding. The test results they nervously waited for never came. The primary care physician's attempts to obtain the results of the procedure were without success, and in the meantime, they were handcuffed by the unknown.

The daughter called Primaris, Missouri's Medicare Quality Improvement Organization, to seek help in obtaining her father's medical records. Primaris offered immediate advocacy, an informal process used to quickly resolve oral complaints that are not serious or substantial in nature. Immediate advocacy was explained to the daughter, and she agreed Primaris could contact the physician and/or the hospital regarding her father's medical records.

Primaris called the physician practice and the hospital where the procedure took place. Representatives from both settings agreed to immediate advocacy. A series of telephone calls followed, and ultimately the daughters' phone number was provided to the corporate compliance officer at the hospital to resolve the issue and make sure her father's medical information was provided to his primary care physician.

The specialist called the father to apologize for the delay in receipt of the report. Primaris' ability to step in and resolve the issue through immediate advocacy saved the father and his daughter any undue stress and the primary care physician received the results they had been waiting for and was able to proceed with necessary follow-up care.

In this instance, immediate advocacy was the perfect solution for obtaining the beneficiary's needed information. Immediate advocacy is a valuable tool for beneficiaries to resolve concerns in a more timely and effective manner than a lengthy peer review.

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# Primaris Opens Up Lines of Communication

It's common knowledge that patients have certain rights when they are being treated at a hospital or primary care physician's office. What might not be so obvious are the steps a patient can take after he or she feels his or her rights have been violated.

One Medicare beneficiary explored all of her options after she felt coerced into having certain treatments and others were performed without her consent. She had been in contact with the treatment facility's patient advocate, but felt he or she didn't do enough to rectify the situation.

The beneficiary then called Primaris, Missouri's Medicare Quality Improvement Organization (QIO), where a Clinical Review Specialist helped her engage in immediate advocacy. This is an informal way to address issues in a faster way than a comprehensive medical record review. The process is designed to take 24 to 48 hours and to engage both sides of the issue in a dialogue to solve the problem.

"It's more satisfying for the beneficiary because it's a quick result compared to a medical record review, which can take three to four months sometimes," the Clinical Review Specialist said.

QIOs all over the country began using immediate advocacy just over a year ago with the goal of helping older adults and their caregivers get results instead of the runaround when dealing with

problems relating to care providers. Although QIOs have no legal authority to make medical providers act in accordance with their recommendations, they do have the right to start a conversation between the two sides, or the provider will be forced to do a formal record review.

Primaris got involved in this situation to act as a third party advocate for the beneficiary who felt she was not getting results by acting on her own. The first step was to contact the facility's patient advocate, explain the situation, and set up a call between the advocate and the beneficiary. Opening up communication between the two parties led to a resolution, where the facility apologized to the beneficiary.

An additional benefit of immediate advocacy in this circumstance was that the hospital implemented an education program for staff about patient rights to ensure that a similar situation will not happen to another patient.

After both an apology and the promise of more staff education, the beneficiary was satisfied with the results. In this case, immediate advocacy was a quick and effective way to eliminate her concerns.

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# Improve Individual Patient Care

Reduce healthcare-acquired infections.

Eliminate adverse drug events.

# Missouri Hospital Expands Surgical Care Improvement

Primaris has worked with Missouri hospitals to improve surgical care for more than a decade. Together Primaris and Missouri hospitals have made impressive improvements in surgical care, reducing surgical site infections and improving patient care.

Citizen's Memorial Hospital (CMH) worked with Primaris to improve surgical care, resulting in 100 percent compliance for seven of eight Surgical Care Improvement Project (SCIP) measures. CMH's performance for SCIP-Infection 3: Prophylactic Antibiotics discontinued within 24 hours after surgery end time showed a 40 percent improvement from baseline to re-measurement.

Citizen's Memorial Hospital credits several focused interventions for both their SCIP performance improvement and subsequent sustainment in their surgical-related care.

Key interventions included:

- Utilizing interventions integrated into the organization's comprehensive electronic medical record, used in both the hospital and affiliated medical clinic settings.
- Establishing standardized physician orders for antibiotic discontinued 24 hours after surgery end time, unless over-ridden by ordering physician, with justification.

- Ongoing physician, clinical, and hospital staff education/training on measure standards and "best-practice" clinical references.

- "Best practice" standards are reinforced with the hospital's nursing staff on a regular basis.

- On a monthly basis, physicians who fall out of compliance with the measures are issued an e-mail notification, signed by the hospital's quality improvement director.

- Compliance with SCIP measures is reported to the medical executive committee on a monthly basis, and to the medical staff, on a frequent basis.

- As deemed appropriate for each individual measure, compliance of each physician is sent to the hospital's designated medical practice credentialing officer.

When the SCIP project ended, CMH's surgical care focus had only just begun. The hospital is presently initiating a new surgical care project beginning with comprehensive education to the patient in the physician clinical setting prior to their scheduled surgery. This effort is being launched organization-wide for CMH-affiliated clinics.

Surgical patients continue to benefit from CMH's partnership with Primaris.

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# Corporations Surpass Others in Restraint and Pressure Ulcers

Primaris staff understands the complexity of improving nursing home care. Our nursing home experts work closely with nursing home staff to individualize their approach. While our quality improvement effort often centers on frontline staff, leadership buy-in can accelerate improvement.

Primaris' collaboration with a nursing home corporation to reduce pressure ulcers and restraints yielded impressive results. Since this group of homes had higher pressure ulcer and restraint rates than the other homes Primaris worked with and higher rates than the state average, it could be expected that their rates of improvement would exceed that of other homes. And they did. What was unexpected is that their rates surpassed the state average and the improvement other homes Primaris worked intensively with made.

Pressure ulcer rates for the corporation's nursing homes dropped to nearly seven percent, compared to the state average of 10 percent. Restraint use fell by nearly 12 percent. Less than one percent of all nursing home residents in this corporation were restrained compared to 12.6 percent at the onset of our work with them.

"Corporate leadership didn't make participation an option; they made it an expectation," said Deborah Finley, director of Nursing Home Services for Primaris.

Finley was introduced by the president to all home's leadership at a statewide corporate

meeting. The president made his expectations very clear by saying, "This is a good group and you will work with them."

The corporation's engagement was ever present. When Primaris staff would run into a barrier with a home, the regional nurses and/or the Director of Operations provided support and encouragement to move the homes forward.

"Knowing the corporation backed what we were doing increased the motivation of the homes and made the needed changes much more acceptable," said Finley.

The large-scale improvement created a lasting relationship and clearly demonstrated the value of corporate leadership. The strides of improvement showed the amazing things that can be accomplished when leadership is committed.

"This was the first time we've experienced outward corporate influence and it yielded huge success," added Finley. "This support came from the president on down through the entire system and it made a world of difference."

The corporation has been a willing partner and has encouraged its homes to continue to work with Primaris on new projects. This successful partnership has also encouraged other reluctant corporations to get on board with Primaris quality improvement projects as well.

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# Pharmacy Should Be Involved in Reviewing Patient's Medications

Medicines cure diseases, manage chronic illnesses and minimize pain and suffering for millions of people each day. But medicines also have the potential to cause harm.

Preventing harm from medications, or adverse drug events (ADEs) are a top priority not only for hospitals but across all healthcare settings. Nearly one in three patients have one or more unintended medication discrepancy at hospital admission and when transferring from one setting to another.

Patients admitted to a hospital commonly receive new medications or have changes made to their existing medications. Without proper review of all prior and current medicines, the new regimen may omit needed medications, unnecessarily duplicate existing prescriptions, or contain incorrect dosages.

Nora Frost\* found herself in this situation. Following a hospital stay, she was transferred to a nursing home. The hospital failed to review her medicine list prior to transferring her. As a result, some of her prescriptions didn't include how much or how often to take, and a prescribed antibiotic did not explain at what point to stop taking it.

Nora was lucky. Her situation did not result in adverse drug event, and she was not readmitted to the hospital. This isn't the case for all patients. Adverse drug events cause over 700,000 emergency department visits each year.

Although Nora's situation did not result in a hospital readmission, the next patient may not be so lucky. Primaris identified the issue to be a system-wide concern that could happen frequently and harm patients if not properly addressed.

Primaris recommended a best practice of involving pharmacy in medication checks before discharge. The hospital is now involving physicians and nursing and pharmacy students in reviewing medication lists.

With Americans taking more and more medicines each day, it's important to create the most accurate list possible of all medications a patient is taking including drug name, dose and frequency.

The hospital is also raising patient awareness through education by asking patients to repeat back medical instructions. This method called the "teach back" method has been proven effective in helping patients remember medical instructions.

By reviewing all patients' medications and making sure they understand medical instructions before leaving the hospital, the risk of an adverse drug event can be minimized.

\*Beneficiary's name has been changed.

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# Missouri Nursing Home Reduces Restraints, Improves Morale

Restraints, once seen as tools to help prevent nursing home residents from injuring themselves, are now recognized as presenting serious health risks to residents, including circulation problems and pressure ulcers. Because the risks of restraints outweigh any potential benefits, Primaris collaborates with nursing homes to reduce the use of restraints.

Primaris helped Cassville Nursing & Rehab in Hurrah, Mo., meet their target for reducing the number of restraints used on residents. In just over a year, the percentage of residents being restrained dropped from 28.9 percent to 2.3 percent.

"I don't think anyone should be restrained," Director of Nursing Janette Stansbury said. "I wouldn't want to be, and I assume nobody else wants to be either. It's a quality of life thing."

When Peggy Neale-Lewis, nursing home program manager for Primaris, met with the home's leadership, the home had the highest restraint usage rate in the state. Neale-Lewis educated the staff about ways to reduce their rate.

"I told them what the limitations were and the data that was going to be collected," Neale-Lewis said. "The restraints were reduced during the first three months from 13 patients to five patients. We made reduction plans for three additional restraints."

The nursing home first compared the data collected from the Minimum Data Set (MDS)

with what they actually observed in their home and realized there were some discrepancies. For example, even residents who were fastening their wheelchair seatbelts on their own as a security measure were being counted as restrained.

"The biggest issue was coding errors and lack of documentation," Stansbury said.

Using the resources provided by Primaris, the nursing home utilized alternative equipment, as well as care planning to reduce the number of restraints used. They also educated families of residents to ease loved ones' fears and reservations about removing restraints.

Reducing the number of restraints had a positive impact on the home's employee morale, from top management to Certified Nursing Aides (CNAs).

"It gives our aides a sense of empowerment," Stansbury said. "Before they felt like they were just babysitters; now they are taking an active role in the care of our residents."

The nursing home credits Neale-Lewis and Primaris for intervening when they did, as Stansbury was not aware of their high restraint usage compared to other facilities around the state.

"Thank god Peggy found us, otherwise we would still be ranking No. 1 in the state," she said.

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