



## 2018 Award Recipients

### ***U of MD Upper Chesapeake***

#### **Circle of Honor Awards**

##### **University of Maryland Upper Chesapeake Medical Center**

*An orthopaedics approach to population health management – Development of a geriatric hip fracture program (GHF)*

Submitted by: Nathaniel Albright, Assistant Vice President, Clinical Service Lines

As the population in Maryland continues to age, the number of acute hip fractures presenting to our hospitals will likely increase. It is estimated that only 50% of hip fracture patients return to their baseline activity level prior to the injury and even more staggering is that elderly adults who suffer a hip fracture are 5 times more likely to be placed in a nursing home for continuous care. U of MD Upper Chesapeake Medical Center sees about 220 acute hip fractures each year and nearly 90% require surgical intervention. The Department of Orthopaedics examined its performance with these patients, and engaged an outside consultant to assist in the management/development of the Geriatric Hip Fracture Program utilizing the latest evidence based clinical pathways, standardized order set, patient and family education materials and data/metric tracking solutions to improve the care of their elderly hip fracture patients. A critical aspect of the program included hiring a dedicated Fragility Fracture Coordinator to lead the program and act as a patient navigator. Through changes in processes, coordination of care, attention to delirium assessment, perioperative cardiac evaluation and management and staff, patient and family education the team launched the Geriatric Hip fracture program in April of 2017. There were four indicators for program success. In just six months, the program saw:

- A seven and one half percent (7.5%) reduction in ED arrival to admission time (18 minutes) for these patients
- A twenty seven percent (27%) or nine hours reduction in admission to surgery time
- A nine percent (9%) reduction in LOS (5.3 days to 4.8 days)

- And a fifty eight percent decrease (58%) in 30 day readmission for this population (12% to 5%)

### **University of Maryland Upper Chesapeake Medical Center**

*STOP snoring with a bang! Reducing postoperative complications by screening patients for obstructive sleep apnea (OSA) risk factors*

Submitted by: Melissa Hunter, Perianesthesia Education Specialist and Lisa Campbell, Director of Perioperative Services

The rising incidence of obstructive sleep apnea, both undiagnosed and diagnosed, has emerged as a significant concern for healthcare providers especially in the perioperative setting. Patients suspected of OSA have an increased incidence of perioperative morbidity and mortality, postoperative complications, difficult intubations, prolonged length of stay, and high rates of intensive care admissions. Medications commonly used in the perioperative setting worsen the upper airway collapsibility, as well as blunt the arousal response in the post-surgical patients. Post-operative complications of apnea, oxygenation desaturation, and cardiac dysrhythmias can occur in the presence of OSA. Many patients first experience complications related to OSA during recovery in the post anesthesia care unit (PACU). Risk factors for OSA were not being screened for at the two hospitals comprising the Upper Chesapeake Health System. A retrospective review revealed that many patients had presented with potential risk factors associated with OSA, and 88% had not been diagnosed with OSA. By implementing the STOP-BANG (**S** Snoring, **T**iredness, **O**bserved apnea, high blood **P**ressure, **B**ody mass Index >35 kg/m<sup>2</sup>, **A**ge > 50 years, **N**eck circumference > 40 cm, **G**ender male) risk assessment tool and providing capnography education to their team the hospital sought to reduce the RRTs due to postoperative complications for surgical patients who presented with risk factors associated with OSA. The results were:

- A 62% decrease in the number of RRTs due to postoperative complications for surgical patients with risk factors associated with OSA in a one year period.
- 1878 patients were screened and 15% were identified with risk factors associated with OSA

# *Minogue Award for Patient Safety Innovation*

University of Maryland Upper Chesapeake Medical Center

*S.T.A.R.T. with the patient: A safe transition and risk assessment tool*

Submitted by: Leslie Clark, Director, Population Health and Lori Wilson: Assistant VP, Patient Services

In 2014 U of MD Upper Chesapeake Medical Center experienced rising trends in readmission rates. Concerned that they were not doing all they could to sustain their community's health, and desiring to improve the hospitals clinical and financial outcomes, a multi-disciplinary Transition of Care workgroup was established. The workgroup identified communication, education and collaboration across the entire continuum of care as necessary to see improvement. The team sought to create an automated risk assessment tool that would identify patients with specific risk factors, beginning with admission. Additionally a plan to mitigate these risks needed to be put in place. The team developed a tool called **START** (**S**afe **T**ransition **A**ssessment and **R**isk **T**ool) and a corresponding START Status Board that could improve communication to and response from other team members appropriate for that patient by generating consults automatically. Through automated consults (outpatient transitional health, behavioral health, palliative care and spiritual care) patient callbacks for follow-up once home, and implementation of the high cost medication awareness intervention by adding a dollar sign to those meds in the EMR the team was able to yield the following results:

- A 9% decrease in readmissions at Upper Chesapeake Medical Center and a 14% decrease at Harford Memorial Hospital between 2016 and July 2017
- A cost savings of \$1,412,318 (Inpatient, Obs and ED visits) by referring to the Comprehensive Care Unit between January and June 2017
- The START tool has generated an increase in psychiatry consults for depression screening from 31 in 2016 to 475 in 2017