AHA/HRET HIIN RESULTS AND BEST PRACTICE SHARING WEBINAR
OUR SUCCESSES: THE JOURNEY, LESSONS LEARNED AND CELEBRATION

Tuesday, October 03, 2017
11:00 a.m. – 12:30 p.m. CT
WELCOME AND INTRODUCTIONS

Lisandra Cuadrado, Program Manager, HRET
WEBINAR PLATFORM QUICK REFERENCE

Mute your computer audio ➔

Download today’s slides and resources

Today’s Presentation

Chat with the Group
# AGENDA FOR TODAY

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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</table>
| 11:00-11:05 AM | Welcome and Introductions                         | Lisandra Cuadrado, MPH  
Program Manager, HRET                                                     |
| 11:05-11:30 AM | Better Care, Smarter Spending, Healthier People: Sustaining and Accelerating Progress | Dennis Wagner  
Director, CMS Quality Improvement and Innovation Group, CCSQ;  
co-director, Partnership for Patients                                       |
|               |                                                   | Dr. Paul McGann  
Chief Medical Officer (CMO) for Quality Improvement, CMS;  
co-director, Partnership for Patients                                         |
|               |                                                   | Shelly Coyle, RN, MS, MBA  
Nurse Consultant, Division of Quality Improvement Innovation Models Testing and Center for Clinical Standard and Quality, CMS |
| 11:30-11:50 AM | Overview of Year One HRET HIIN Results            | Jay Bhatt, D.O.  
President, HRET  
Senior Vice President and Chief Medical Officer, AHA                      |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:50-12:10 PM</td>
<td>Hospital Best Practice Stories</td>
<td>Hospitals who have made significant strides during the project will share their lessons learned and results on the following topics:</td>
</tr>
<tr>
<td></td>
<td>Readmissions Fishbowl</td>
<td>Anthony W. Baird DSc, CPHQ, Executive Administrative Director</td>
</tr>
<tr>
<td></td>
<td>Memorial Medical Center</td>
<td>Medical Staff Services, Clinical Quality</td>
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<tr>
<td></td>
<td>Las Cruces, NM</td>
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<tr>
<td></td>
<td>Readmissions Fishbowl</td>
<td>Dorothy Rice RN, BSN, MBA, Director of Quality</td>
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<tr>
<td></td>
<td>Ransom Memorial Hospital</td>
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<td></td>
<td>Topeka, KS</td>
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<td></td>
<td>Process Improvement in Rural CAHs</td>
<td>Casey Driscoll, MHA, HIIN/STRIVE Project Director</td>
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<tr>
<td></td>
<td>Phillips County Hospital</td>
<td>Ward C. VanWichen, FACHE, CEO</td>
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<td>Malta, MT</td>
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<tr>
<td>12:10-12:20 PM</td>
<td>Fellowship Best Practice Story</td>
<td>Fellows who have made significant strides during their fellowship program will share their lessons learned and results on the following topics:</td>
</tr>
<tr>
<td></td>
<td>QI Fellowship</td>
<td>Jennifer Macabuag MBA-HCM, MSN, BSN, RN, Quality Coordinator</td>
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<td></td>
<td>Stamford Health</td>
<td></td>
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<td></td>
<td>Stamford, CT</td>
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<tr>
<td>12:20 – 12:30 PM</td>
<td>Discussion, Reflection and Next Steps</td>
<td>HRET will share reflections on the project, accomplishments and continuing the improvement work to reduce patient harm across the nation during Year Two</td>
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<td></td>
<td>Charisse Coulombe MS, MBA, CPHQ, Vice President, Clinical Quality HRET</td>
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HIIN project: Celebrations, Learnings and Moving Toward the Future

AMERICAN HOSPITAL ASSOCIATION/
HEALTH RESEARCH & EDUCATIONAL TRUST
OCTOBER 3, 2017

DENNIS WAGNER, MPA
PAUL MCGANN, MD
QUALITY IMPROVEMENT & INNOVATION GROUP

CENTERS FOR MEDICARE AND MEDICAID SERVICES
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Thank You

- For the hard work you are doing to improve and transform our nation’s healthcare system.

- For your commitment and actions to improve the care of the patients and clients we serve.

- For your leadership and participation with CMS, the American Hospital Association/HRET/HIIIN, & each other.
Purposes of Session

- Share current & emerging CMS and HHS priorities

- Provide update on strong progress and good work to reduce patient harm and readmissions, both nationally and locally

- Request your leadership and help in next stages of this work

- Explore strategies and approaches for increasing impact and joy while maintaining resilience in our shared work to provide great care
Delivery System and Payment Transformation

**Current State** –
Producer-Centered

- Volume Driven
- Unsustainable
- Fragmented Care
- FFS Payment Systems

**Future State** –
People-Centered

- Outcomes Driven
- Sustainable
- Coordinated Care
- New Payment Systems (and more)
  - Value-based purchasing
  - ACOs, Shared Savings
  - Data Transparency
CMS Strategic Goals

The CMS strategy will be built on one main goal: **Put Patients First**
Centers for Medicare and Medicaid Services: Strategic Goals

1. Empower patients and doctors to make decisions about their health care.

2. Usher in a new era of state flexibility and local leadership.

3. Support innovative approaches to improve quality, accessibility, and affordability.

4. Improve the CMS customer experience.
Key Priorities Identified by Health and Human Services

- Opioids
- Behavioral Health
- Obesity
- Reducing Burden
CMS has established large-scale, action-focused networks to support state and local quality improvement and to generate results for patients.

- **Partnership for Patients**
  - 4,042 Hospitals

- **Transforming Clinical Practices Initiative**
  - 105,000+ Clinicians

- **End Stage Renal Disease Networks**
  - 6,000 Dialysis Facilities

- **Quality Innovation Networks - Quality Improvement Organizations**
  - 250+ Communities
  - 12,000+ Nursing Homes
  - 3,800 Home Health Organizations
  - 300 Hospice
  - 1,700 Pharmacies

- **MACRA and Quality Payment Program - Small, Underserved, Rural Support (SURS)**
  - Up to 200,000 Clinicians
Our “Way” of Operating to Achieve Results

- Bold, Clear Aims -- Implemented at Scale
- Focus on Results
- Do More of What Works
- Make Best-In-Class Performance, Common Performance
- Tight About the “What” Outcome; Flexible on the “How”
- Foster and Foment Joy in Work
Partnership for Patients Established 2 New Breakthrough Aims for 2015 thru 2019

- 20% Reduction in All-Cause Patient Harm
- 12% Reduction in 30-Day Readmissions
16 Hospital Improvement Innovation Networks

- American Hospital Association, Health Research Education Trust (AHA-HRET)
  - 34 State Hospital Associations
- Carolinas HealthCare System
- Dignity HealthCare
- Healthcare Association of NY State
- HealthInsight
- Hospital & Healthsystem Association of Pennsylvania
- HSAG
- Iowa Healthcare Collaborative
- Michigan Health & Hospital Association
- Minnesota Hospital Association
- New Jersey Hospital Association, HRET
- Ohio Children’s Hospital Solutions for Patient Safety
- Ohio Hospital Association
- Premier
- Vizient
- Washington State Hospital Association
Partnership for Patients
Number of Participating Hospitals by State
(4042 Hospitals Participating as of August 9, 2017)
AHA-HRET Data is Showing Strong Improvement on Multiple Dimensions of Work.
National Challenges Include Readmissions, MDRO, Falls

Note: Sepsis and Worker Safety do not meet data collection thresholds
32 High Performing Hospitals!

CrossRidge Community Hospital, Wynne, AR
Little River Memorial Hospital, Ashdown, AR
Lincoln Community Hospital, Hugo, CO
Southwest Memorial Hospital, Cortez, CO
St. Anthony Summit Medical Center, Frisco, CO
Adams Memorial Hospital, Decatur, IN
Clara Barton Hospital, Hoisington, KS
Clay County Medical Center, Clay Center, KS
Community Memorial Healthcare, Marysville, KS
Kiowa District Hospital and Manor, Kiowa, KS
Sabetha Community Hospital, Sabetha, KS
Wamego Health Center, Wamego, KS
Carroll County Memorial Hospital, Carrollton, KY
Richland Parish Hospital, Delhi, LA
Winston Medical Center, Louisville, MS
Carroll County Memorial Hospital, Carrollton, MO
Excelsior Springs Hospital, Excelsior Springs, MO
Pemiscot Memorial Health System, Hayti, MO
Beartooth Billings Clinic, Red Lodge, MT
Benefis Teton Medical Center, Choteau, MT
Big Sandy Medical Center, Big Sandy, MT
Mineral Community Hospital, Superior, MT
Northern Rockies Medical Center, Cut Bank, MT
Lexington Regional Health Center, Lexington, NE
Ashley Medical Center, Ashley, ND
Linton Hospital, Linton, ND
Southwest Healthcare Services, Bowman, ND
Tioga Medical Center, Tioga, ND
Memorial Hospital, Stilwell, OK
Pauls Valley General Hospital, Pauls Valley, OK
Stroud Regional Medical Center, Stroud, OK
Weatherford Regional Hospital, Weatherford, OK
Aims & Results: a choice we make every day
We have made a Leadership Choice – Breakthrough Aims

“I want to see something much better.”
Build the System: Stand For Aims, Enroll Others, Persist, Learn, Evolve, Grow...
"I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to the earth."

--- President John F. Kennedy,
Delivered in person before a joint session of Congress
May 25, 1961
First Round of Partnership for Patients Also Focused on 2 Bold Aims

**Goals:**

- **40%** Reduction in Preventable Hospital-Acquired Conditions
  - 1.8 Million Fewer Injuries | 60,000 Lives Saved

- **20%** Reduction in 30-Day Readmissions
  - 1.6 Million Patients Recover without Readmission

*Purpose*

National Results on Patient Safety: Substantial Progress Thru 2015

- 125,000 lives saved
- $28B in cost savings
- 3.1M fewer harms

Success in Achieving Bold Aims Has Led to New Bold Aims!

Number of Harms per 1,000 Discharges

New Goal: 97
Pause for Reflection

What are your experiences with using bold aims to drive results?

What bold aims are you committed to now in your work and/or in your life?
What Are the Sources of Resilience?

- Purpose
- Partners
- Perspective
- Choice
- Embracing Change; Leading Change
- Wholeheartedness
A Wholehearted Commitment to Clear **Purpose** is a Powerful Source of Resilience

- 125,000 lives saved
- $28B in cost savings
- 3.1M fewer harms
Requests for Information: 12th SOW & CMMI

12th SOW RFI

- The Centers for Medicare & Medicaid Services (CMS) seeks information about the content and strategy for deploying the 12th SOW for Quality Improvement Contractors.

- The Request for Information (RFI) could be accessed here: [https://www.fbo.gov/index?s=opportunity&mode=form&id=e91ae1daf1fd5aa41b18525f00d777&tab=core&cview=0](https://www.fbo.gov/index?s=opportunity&mode=form&id=e91ae1daf1fd5aa41b18525f00d777&tab=core&cview=0)

- **Posted Date:** 28 September 2017 at 8.44am

- **Response Date:** 19 October 2017 at 4pm ET.

- **ADDRESS:** Please submit all questions to NQIIIC@cms.hhs.gov

- To register for the upcoming QI Industry (October 5, 2017) Click here: [https://attendee.gotowebinar.com/register/7051232226249357827](https://attendee.gotowebinar.com/register/7051232226249357827)

CMMI RFI

- While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center.

- Through this informal Request for Information (RFI) the CMS Innovation Center (Innovation Center) is seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes.

[https://innovation.cms.gov/initiatives/direction/](https://innovation.cms.gov/initiatives/direction/)
HIIN Guiding Themes...

**EQUITY** — improving quality must be done through the lens of increasing equity.

**PATIENT-FOCUSED** — patient should always be a crucial component of any care team.

**STRATEGIC PARTNERSHIPS** — HRET will serve as a facilitator, pulling together the voice, resources and expertise of other key professionals.

**HIGH RELIABILITY** — HRET will guide hospitals with strategies and resources needed to build and infrastructure and nurture the culture necessary for sustainability.
By 2019, reduce all-cause inpatient harm by 20 percent and readmissions by 12 percent.
Bold Aims...

+ Provide technical assistance and coaching

+ Create cross-cutting resources

+ Develop clinical topic-specific resources

+ Host peer-to-peer networking opportunities

+ Share best practice hospital stories
HRET HIIN on the road...
INVITES YOU TO A
ADVERSE DRUG EVENTS (ADE) VIRTUAL EVENT

FEBRUARY 14
2017 | VIRTUAL
12:00 – 12:50 P.M CT

Register and view the agenda at
www.hret-hiin.org/events

ADJUNCTS AND ALTERNATIVES TO OPIOIDS FOR PAIN: IT’S ALL ABOUT LOVE
INVITES YOU TO A
ADE FISHBOWL SERIES

MAY 2, 2017
VIRTUAL | 11 A.M. – 12 P.M. CT

Register and view the agenda at www.hret-hiin.org/events

OPIOID SAFETY

Are you struggling with implementing safer processes for opioid management? Having trouble getting started or in spreading success? Are the naysayers bogging you down?

Join the HRET HIIN on May 2nd for our first “Fishbowl” event where you will watch brave organizations learn by doing...in real time. Join in as they develop aim statements and measures, organize small improvement teams and begin rapid cycle Plan DO Study Act (PDSA) learning and improvement cycles. See how small tests of change can lead to learning from failure; failure that rapidly leads to success. The intended audience is for hospital teams working to reduce ADEs due to opioids.

PARTICIPATING HOSPITALS
Medical West
Bessemer, Alabama
Newton-Wellesley Hospital
Newton Lower Falls, Massachusetts
The Heart Hospital Baylor
Denton, Texas
Riceland Medical Center
Winnie, Texas
Sidell Memorial Hospital
Sidell, Louisiana

HRET HIIN SAFETY NETWORK TO ACCELERATE PERFORMANCE (SNAP): Identification, Treatment and Transfer to Referral Centers of Patients with Sepsis or Potential Sepsis

WHY SNAP?
A SAFETY NETWORK TO ACCELERATE PERFORMANCE (SNAP) IS A VOLUNTARY LEARNING NETWORK THAT WILL ADDRESS EMERGING BEST PRACTICES AND DEVELOP INTERVENTIONS. IF YOU ARE AN EARLY-ADOPTER HOSPITAL AND ARE INTERESTED IN CONTRIBUTING TO A NEW KNOWLEDGE BASE BY SETTING FORTH BOLD AIDS AND TESTING INNOVATIVE PRACTICES, JOIN OUR INFORMATIONAL SESSION AND SUBMIT AN APPLICATION.

WHO SHOULD APPLY
The Sepsis Transfer SNAP will consist of up to 15 hospital pairs (One referring
SEPSIS MORTALITY REDUCTION

PREVENTING ADVERSE DRUG EVENTS (ADE)
Big Results...

HIIN Data October 2016 – May 2017

39,167
HARMS AVOIDED

6,006
READMISSIONS AVOIDED

$305M
COSTS AVOIDED
A Story Told Through HIIN Participation...

1635 Hospitals
821 Rural - 566 CAHs - 814 Urban
Key Strategies...

OUR APPROACH
Partnering Beyond the Quality Team

LEADERSHIP engagement

PHYSICIAN engagement

PATIENT and FAMILY insights

+ Fellowships

+ Safety Networks to Accelerate Performance (SNAP)

+ UP Campaign

+ Listserv
Power in Partnerships...
HRET HIIN PERCENT IMPROVEMENT, BASELINE – 2017
Year 1 Actual: Baseline compared to Oct 16 through June 2017, except for readmissions (through May 2017)
Data submitted as of August 1, 2017

A Story Told Through HIIN Data…
## A Story Told Through Data...

<table>
<thead>
<tr>
<th>Partnership for Patient Aims</th>
<th>Year 1 Target</th>
<th>Year 1 Actual</th>
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<tbody>
<tr>
<td>% Reduction of Adverse Drug Events</td>
<td>7%</td>
<td>19.7%</td>
</tr>
<tr>
<td>% Reduction of Central Line-Associated Bloodstream Infections</td>
<td>10%</td>
<td>19.5%</td>
</tr>
<tr>
<td>% Reduction of Pressure Ulcers</td>
<td>10%</td>
<td>51.4%</td>
</tr>
<tr>
<td>% Reduction of Sepsis &amp; Septic Shock</td>
<td>7%</td>
<td>36.5%</td>
</tr>
<tr>
<td>% Reduction of Surgical Site Infections</td>
<td>10%</td>
<td>15.5%</td>
</tr>
<tr>
<td>% Reduction of Venous Thromboembolism (Post-op VTE/DVT)</td>
<td>7%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Estimated Number of Harms Avoided Overall</td>
<td>26,635</td>
<td>39,167</td>
</tr>
</tbody>
</table>
A Story Told Through HIIN

Hospitals reporting no events:

- ADE - 245
- CAUTI - 185
- Falls - 74
- Pressure Ulcers - 43
- C. Difficile Infections - 126
- MRSA Infections - 127

184 hospitals have achieved a 12% reduction or higher in their all-cause readmissions rate

***Oct 2016 – May 2017***
Moving Forward

- Continue emphasis on data collection and analysis
- Partner with states
- Focus group informed content
- Provide action plans for data collection
- Target readmissions, culture of safety, sepsis, ADE, pressure ulcers, falls
HRET HIIN: Year Two

+ WakeUp Campaign
+ GetUp Campaign
+ SoapUp Campaign
+ ScriptUp Campaign
MEMORIAL MEDICAL CENTER is a 199 bed general acute hospital in Las Cruces, New Mexico operating as a tertiary referral facility for 7 smaller regional hospitals.
Memorial Medical Center
Readmission Reduction

• Memorial Medical Center is on a journey to achieve the Duke LifePoint Affiliate status.
  – Components of the evaluation include qualitative evaluations of all harms, and a positive trend in reduction.
  – Readmissions are one of the included topics, and we treat all readmissions as a patient harm.

• As the tertiary referral facility for 7 other regional medical centers and hospitals, we get critically ill patients every day. We wanted to make sure that these patients, as well as our own, were discharged appropriately, and with appropriate resources. Readmissions were a component of these discussions.

• Historically, we saw an increase in readmissions in the winter and spring of each year. MMC made the decision that evaluating all readmissions, and reducing them wherever possible was the right thing to do for the patients and families.
Memorial Medical Center
Readmission Reduction

- Memorial Medical Center has some variability in regards to readmissions, and adding readmissions to our harms reviews made the reduction a high priority.
- Successfully reducing readmissions improves patient and family satisfaction, decreases cost of care, and favorably impacts our value-based purchasing statistics.
- We found that multiple interventions were required to address all of the complex issues and stressors related to readmissions. These included (to name a few):
  - Prioritizing readmissions as a harm
  - Daily reviews of all harms
  - Case Management in the ED
  - The Post-Acute Care Collaborative (PACC)
  - Family Practice Clinic PharnD. 4th year Student evaluation
  - More discussed on the summary page at the end.
• Las Cruces New Mexico has a demographic mix, 49% Hispanic, 45% Caucasian, 3% African-American, and a mix of Asian and Middle Eastern people. It is also one of the poorer cities in the United States when measuring per capita income. Our Medicare & Medicaid mix averages 80% plus.

• MMC created a Post-Acute Care Collaborative and invited all post-acute care providers, including DME, home health, SNFs, LTACs and rehab facilities.

• Memorial Medical Center showed a 5.9% readmission rate overall for the month of August 2017. Our target is 6.9%, with a Baseline of 8.2%
• Nationally, we participate in the Duke LifePoint Affiliate achievement.
• We also reached out to our AHA partners. State-wise, we participate in the New Mexico HIIN/HRET projects and with the QIO< HealthInsights.
• The results showed opportunities in the winter and spring periods of time, and also showed that we specifically had opportunities in HF, pneumonia and TJR discharges.
• 50% of the patients admitted to MMC do not have primary care providers, or any providers for at all. The ED is often used as a clinic.
• We have a family practice clinic associated with our Family Practice Residency program, and we began funneling the no PCP patients thru the clinic for follow-up.
• In the FP clinic, we created a resource service by utilizing a 4\textsuperscript{th} year PharmD. student to review mediations and other resources available to these patients, demonstrating a 3.5% reduction in this population.
<table>
<thead>
<tr>
<th></th>
<th>LifePoint Baseline (2014)</th>
<th>LifePoint Goal (15.3% Reduction)</th>
<th>2016</th>
<th>1Q16</th>
<th>2Q16</th>
<th>3Q16</th>
<th>4Q16</th>
<th>2017</th>
<th>1Q17</th>
<th>2Q17</th>
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<tbody>
<tr>
<td>Hospital-Wide</td>
<td>8.2%</td>
<td>6.9%</td>
<td>6.8%</td>
<td>6.5%</td>
<td>6.9%</td>
<td>7.0%</td>
<td>6.9%</td>
<td>7.2%</td>
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<td>AMI</td>
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<td>9.1%</td>
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<td>4.5%</td>
<td>13.2%</td>
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<td>14.8%</td>
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<tr>
<td>CABG</td>
<td>14.6%</td>
<td>12.3%</td>
<td>6.7%</td>
<td>9.1%</td>
<td>0.0%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.6%</td>
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<td>CHF</td>
<td>17.7%</td>
<td>14.9%</td>
<td>19.0%</td>
<td>18.8%</td>
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<td>18.2%</td>
<td>20.8%</td>
<td>20.9%</td>
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<tr>
<td>COPD</td>
<td>15.6%</td>
<td>13.1%</td>
<td>15.7%</td>
<td>11.5%</td>
<td>18.8%</td>
<td>17.2%</td>
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<td>PNE</td>
<td>11.1%</td>
<td>9.3%</td>
<td>10.9%</td>
<td>7.8%</td>
<td>7.9%</td>
<td>18.2%</td>
<td>12.6%</td>
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<td>10.4%</td>
<td>13.4%</td>
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<td>STROKE</td>
<td>8.2%</td>
<td>6.9%</td>
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<td>14.3%</td>
<td>0.0%</td>
<td>8.3%</td>
<td>9.5%</td>
<td>20.0%</td>
<td>0.3%</td>
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<tr>
<td>THR/TKR</td>
<td>3.4%</td>
<td>2.9%</td>
<td>4.2%</td>
<td>4.4%</td>
<td>6.0%</td>
<td>1.6%</td>
<td>4.2%</td>
<td>6.6%</td>
<td>5.1%</td>
<td>5.7%</td>
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</table>
• Readmissions affect patient satisfaction, cost money that are often not reimbursed, and affect peoples lives and well being. Allowing rampant readmissions is just bad medicine.

• If your intervention was implemented in all hospitals, organizations and/or communities, I could see a stabilization of readmissions maybe not at the 5.9% rate, but at something lower than is seen today.

• The interventions discussed worked at Memorial Medical Center and may work at other facilities with facility-specific modifications, creating a decrease in overall readmissions.
• The interventions discussed take time, both in terms of people power, and calendar time for interventions to prove themselves out. You don’t hit a home run every time you are at bat, and the same applies here. Persistence is required, and constant surveillance.

• MMC use case management, quality and PI personnel, data abstractors, HIM and coders, clinical documentation specialists, and of course the providers.

• Again, to be successful, persistence and constant surveillance are required to be successful at anything and readmission reductions are no different.
Key points

– Prioritizing readmissions as a harm
– Daily reviews of all harms
– Provider report cards, including readmissions, beginning with employed providers and expanding to all.
– Case Management in the ED
  • Nursing education on the importance of Discharge Status
– The Post-Acute Care Collaborative (PACC)
– Family Practice Clinic PharmD. 4th year Student or DNP evaluation
– Heart Failure Clinic
– Proposed Mobile Integrated Health (MIH) Partnered with Fire Departments and EMS (Homeless and frequent 911 and readmission flyers)
– Behavioral Patient discharge evaluations
RANSOM MEMORIAL HOSPITAL
Reducing Readmissions 2017

Small PPS hospital
44 Licensed Beds
ED visits-13,000 annually including trauma

Services include:
Surgical-Ortho, EENT,
Gynecology, Urology,
Podiatry, OB, Urology
Medical-Neuro,
Internal Medicine,
Pulmonology, Cardiology,
Nephrology

AIM: Reduce all cause readmissions to ≤ 5%
by December 2017.

Left to Right: Tammy Newberry,
David Bowers, Angie Welch, Stacy
Steiner, Rita Demeter
Front Row: Kelli Boetel, Dorothy
Rice, Cindy Tiblow
<table>
<thead>
<tr>
<th>Aim</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease all cause readmissions to 5% or less by Dec 2017.</td>
<td>Reducing overall readmissions improves quality of life for our patients and community. It also decreases cost for the patient and the hospital. Readmission efforts in the past led to a reduction in readmissions to 6% however we remained at 6% for 2 years &amp; knew we owed it to our patients to work to further reduce readmissions.</td>
</tr>
</tbody>
</table>
Measures

• **Outcome Measures:** *RMH will decrease overall readmission rates to 5% or less by Dec 2017. By doing so, we would improve overall quality of life for our patients. Not placing a focus on readmits, might result in an increase in readmissions which increases cost as well.*

• **Evidenced Based Process Measures Used:** *72 hour post discharge phone calls by nursing and pharmacy when a high risk medication is prescribed. PFAC peer to peer rounding on all inpatients with specific questions related to readmission and understanding their medications. Use of resources helped guide our efforts such as IHI, AHA, Studer Group, HCAHPS, the Boost Tool and Aspire Tool.*

• **Balance Measures:** *Assuring staff accountability to complete the discharge phone calls. Educating staff and PFAC members on the why and how so all can be on the same page.*
READMISSIONS DATA HAS BEEN COLLECTED, ANALYZED AND REVIEWED FOR DISPARITY DATA FOR THE PAST 2 YEARS

FINDINGS: Our hospital receives about 2% Hispanic and other ethnicities so this was not our top challenge. From our community data, we were concerned poverty and behavioral health issues could pose a higher risk or threat for the readmitted population.

- Identified the majority of our readmissions are the Medicare population and the top diagnosis is Sepsis.
- Hospital collaborates well with our local Behavioral Health organization (Elizabeth Layton Center) to provide the resources for behavioral concerns. These are rarely our readmitted patient.
- We are currently working on the higher risk sepsis patient on discharge to provide additional resources as needed and to assure they have a f/u appt within 72 hrs.
- We have worked with our local EMS providers who have the Paramedicine program and are discussing having a home visit for the patient discharged with a Sepsis diagnosis.
- Our Pharmacy Director worked with a local pharmacy to provide discharge medications to our patients on discharge to promote the teaching and understanding of the medications before discharge, this will be implemented in the near future.
READMISSIONS DATA HAS BEEN COLLECTED, ANALYZED AND REVIEWED

- Patient & Family Advisory Council has been utilized to start peer rounding since July 2017.
  - Patients enjoy the PFA’s visiting them and feel free to discuss their concerns/issues at the time.
  - Education has been provided along with ongoing re-education and discussions with the PFA’s. Some are not as comfortable as others but are growing in the role.
  - Our overall HCAHPS scores have increased for the 3rd qtr (July-Sept 2017) in which PFAC rounds may have contributed to as well as the work staff is doing on rounding, discharge phone calls, etc.
RMH is certain the AHA/HRET/HiIN projects have contributed to our outcomes achieved. We participated in the Readmissions Fishbowl project which helped keep us focused and driven to make a difference for our patients by reducing overall readmissions!

➤ We love, love, love the resources and webinars provided by these organizations!
  • Evidenced Based
  • Success stories from other hospitals that have paved the road!
  • Tool Kits
  • Numerous tools & resources available to help hospitals organize their projects.

➤ The team has learned that we have to refocus the efforts time and time again in small test of change to assure accountability and to drive the success!

➤ Patients continue to teach the team through our communications with them through post discharge phone calls, readmission interviews and discharge planning. We know that it is very individualized per patient for their discharge needs.

➤ Patients do wish to take part in their health and improving it!
Ransom Memorial Hospital
Overall Readmission Rates
AIM: Achieve Hospital Readmission to < 5%

July: Pharmacy started 48hr post d/c med calls
June: Initiated 72hr post d/c
5%
CALL TO ACTION

• First, it is important to complete Readmission Data Collection and Analyses with readjustment of practice/processes based on your readmission data.
• Use small test of change to implement those practice or process changes so you can rapidly change, not getting caught up in many details.
• Consider post discharge phone calls/visits to assess effectiveness of your processes such as discharge planning/teaching by engaging your patients.
• Consider use of a PFAC to round and assist the team in addressing specific patient needs such as the readmitted patient population and why they think they were readmitted. Patients will communicate freely to a peer.

If the above interventions were implemented in hospitals, organizations and communities we envision a reduction in readmissions. Will you/your hospital join me in using your data to collaborate with your patients and Patient Family Advisors to address the issues identified through small test of change?
Phillips County Hospital is a 6 bed CAH with an attached RHC located in Malta, which is on the northeastern plains of Montana.

Phillips County Hospital Practitioners
- Edwin Medina, MD, Chief of Staff
- Sherry Garriett, FNP-BC
- Theresa Ohl, FNP-BC
- Shane Jensen, FNP-C

Senior Leadership
- Ward C. VanWichen, CEO
- Steph Denham, CFO
- Lonna Crowder, DON
- Donny Bagley, Lab/X-Ray Manager
- Karyn Jenson, RN, Clinic Nurse Manager
OUR STORY

- Over the past 1 to 2 years there was a sense of a growing division between Medical Staff and Administration that was affecting the culture of PCH.
- We knew that we needed to do something different and that to do something different would bring medical staff and administration back together, partnering and collaborating to lead our organization now and into the future for our community and for quality care and services.
- That “something different” came in an opportunity to apply for and have our Chief of Staff and CEO attend the Adaptive Leadership for Medicine: Physicians and Administrators; Partners in Leadership in Chicago. Which they did and... They found out that they were not alone!

Other leaders at the conference were facing similar challenges around medical staff and administration wanting the same things but maybe speaking different language and having different processes/timelines.
Phillips County Hospital
A story about HOW incorporation of Adaptive Leadership for Medicine principles has changed, improved and moved them forward

- PCH had already been working and trying different things to resolve this issue with the involvement of the Board, Med Staff and Administration, yet they:
  - Weren’t having many successes
  - Never gained much momentum
  - Partners in Leadership; being that something different and then maybe the one piece of the pie that sticks?
- By not addressing the growing disconnect, additional tensions would have grown and directly impacted our quality patient care, our organizational culture and ultimately we could have had staff leave our organization (Med Staff, Administration and others)
- In efforts to change, improve and support a better culture, PCH had to embrace their faults and adaptive leadership challenge – of this growing disconnect – and start anew working together differently.
Phillips County Hospital

A story about HOW incorporation of Adaptive Leadership for medicine Principles has changed, improved and moved them forward

- Chief of Staff and CEO were able to spend quality 1-on-1 time, establishing a stronger bond and deeper understanding both professionally and personally
- After attending the conference, each leader brought back Adaptive Leadership principles
- Both leaders had open individual conversations with their respective Medical & Admin. staff to improve those lines of communication and trust
- Those conversations were documented and common themes identified by each leader then Chief of Staff and CEO came together to formulate an agenda for the first ever PCH “Adaptive Leadership Counsel” meeting to start addressing those issues, questions and/or concerns identified.
- PCH is now holding monthly luncheons with Board Chair, Chief of Staff and CEO on how to utilize principles/tools of the Adaptive Leadership on Observation – Interpretation and Intervention.
- PCH has also incorporated the Adaptive Leadership principles into Department Head & Board meetings

PCH has changed and improved by tackling this challenge!
ADAPTIVE LEADERSHIP PRINCIPLES
To carry US/PCH forward

• **Assume positive intent**

• **Take a pause/ “get on the balcony”** – to look from other perspectives and get different insights and information

  “Each new view of the horizon is a glance through a different turn of the kaleidoscope” – Egon Zehnder

• **Be Diagnostic** - OBSERVE – INTERPRET – INTERVENE (repeat the continual/ongoing leadership process)

• **Technical vs Adaptive Challenges** – take different types of work and approaches

• Take and seize the opportunity to **hit the “RESET” button**

• **Leadership skills we will ALL need to be successful and continue to move PCH forward**

  - **Foster adaption** – helping people develop the “next practice” to thrive while excelling at today’s best practice
  
  NOTE – distinguish the essential from the expendable

  - **Embrace disequilibrium** – enough to induce change but not so much that it is flight, flee or freeze “keep your hand on the thermostat” and remain in the Productive Zone of Disequilibrium

  - **Generate leadership** – give people the opportunity to lead experiments that will help adapt to changing times

• **Take care of yourself**

  - Give yourself permission to be both optimistic and realistic

  - Find sanctuaries – where you can reflect on events and regain perspective

  - Reach out to confidants – ideally someone external

  - Bring more of your emotional self

  - Don’t lose yourself in your role -
A story about HOW incorporation of **Adaptive Leadership for medicine Principles** has changed, improved and moved them forward

- If other facilities are having a disconnection between Medical staff and Administration PCH recommends it **needs** to be addressed in an appropriate and timely fashion for what works best for you, but would greatly recommend adding in the principles of Adaptive Leadership into your tool bag.
  - Identify and develop your TEAM
  - Attend one of the offered workshops on Adaptive Leadership
  - Utilize the Adaptive Leadership principles (slide 7 taken from the training)
  - HRET webinars
  - State Hospital Association support
  - Cynosure Improvement Advisors
  - Council and support from your peers and/or other organizations
  - Any and all resources at your disposal to change/improve.
Phillips County Hospital

A story about HOW incorporation of **Adaptive Leadership for medicine Principles** has changed, improved and moved them forward

• We at PCH feel the principles of Adaptive Leadership are very easy to initiate and sustain into any organization and culture.

However – **it will be work!!!** Add them into your tool kit.

• **Key points to remember in becoming a better leader:**
  ✓ Assume Positive Intent
  ✓ Take a pause – Get on the Balcony
  ✓ Be Diagnostic – Observe – Interpret – Intervene (remember – this is cyclic!)
  ✓ Hit the reset button
  ✓ Take care of yourself
At Phillips County Hospital our **Mission** is “to make a difference in healthcare” and our **Vision** is “to be a leader in healthcare.”

Join US in making a difference and being Adaptive Leaders for healthcare

**ALWAYS** - remember that out of challenges come opportunities to learn, grow, change and improve.

Thank you and Good luck!
A 305-bed, not-for-profit hospital providing area residents (Fairfield and Westchester counties) with access to the latest technology using a compassionate, patient-centered care approach located in Stamford, CT.

One of only 17 acute care hospitals in the nation with Planetree designation that allows us to focus on patient-centered care.

A major teaching affiliate of the Columbia University College of Physicians & Surgeons.

Now among roughly 7 percent of hospitals nationwide to have been granted Magnet status by the American Nurses Credentialing Center (ANCC).
The Challenge

The Tobacco-3 (Tobacco Use Treatment Provided or Offered at Discharge) and Tobacco-3a (Tobacco Use Treatment at Discharge) was released as a newly adopted inpatient psychiatry measure in January 2016 by The Joint Commission. The measure pertains to patients identified as tobacco smokers within the past 30 days who were referred to outpatient tobacco cessation counseling and received FDA approved cessation medications at discharge.

Specific challenges to measure compliance noted were:

• Lack of outpatient tobacco cessation program availability for patients within the area
• Patient refusal when referred to tobacco quit line
• Lack of documentation and communication to patient of confirmed date, time, and provider for the scheduled appointment
1. If challenge is not addressed
   • Increased quality measure outliers
   • Will affect hospital quality measure performance score, ratings, and reimbursement
   • Will limit availability of tobacco cessation programs within the community

2. If challenge is successfully addressed
   • Will increase the psychiatric inpatient unit referral compliance for outpatient tobacco cessation counseling program to 95% by June 2017 for psychiatric patients identified as tobacco smokers.
   • Increased patient motivation to quit smoking
   • Efficient access to outpatient tobacco counseling sessions

3. Evidenced based intervention
   • Behavior counseling through individual or group sessions combined with medications
   • Tobacco cessation program
1. Background/context that impacted topic selection
   • 13 hospitals nationally with 100% TOB-3a compliance rate
   • Poor documentation of communication to the patient of the confirmed date, time, and provider for the scheduled appointment
   • Lack of outpatient tobacco cessation program availability for patients within the area

2. Project Team
   • Director of Quality Chief, Department of Psychiatry Quality Coordinator, Nurse Manager, Activity Therapy Coordinator Inpatient Psychiatry, Director of Medical Services, Respiratory Therapists / Trained Tobacco Specialists

3. Results
   • First Outpatient Tobacco Cessation Program developed and conducted
   • Referral compliance increased
   • Documentation of appointment improved
1. How did your organization’s participation in any national, state or local projects contribute to the outcome achieved?
   - Developing our own hospital tobacco counseling program for discharged tobacco smokers served as an avenue for motivating patients to quit tobacco & improve lifestyle

2. What did the results/outcome teach the team?
   - There were 13 hospitals nationally who had 100% compliance for TOB-3 measure
   - When a social worker forgets to review MD’s tobacco use history, it correlates to having no referral documentation for identified smokers
   - Documentation is a must
   - Automatic referral of tobacco smokers to outpatient counseling increases compliance to referral measure
Run chart & RESULTS OF DATA

Percentage of Tobacco Smokers Without Social Worker Referral Documentation on EMR

Psychiatric Social Worker Education on Cessation Referral Documentation was Started

Outpatient Tobacco Cessation Counseling Referral Compliance

Increase in compliance after the 1st Tobacco Outpatient Cessation Counseling Program conducted on December 14, 2016 was launched

Staff Education on Cessation Referral Documentation & Counseling Program Flow Presentation Done 3rd wk of Nov

Data Collection Done
1. Call to action for others with a similar challenge
   • Present evidence that justifies how a possible intervention could work out
   • Continuously educate, support, and assist the staff challenged by new protocols & measure specification
   • Provide a detailed table of task to staff on quality measure specifics, where to look, and document on the chart

2. My vision when implemented
   • Decreased patient risk for serious health problems
   • Will serve as a problem-solving approach to increase smoking cessation

3. Reason to implement this intervention
   • Motivate patients to quit smoking
   • Increase accessibility to tobacco cessation counseling program within the hospital grounds
   • Increase hospital compliance with tobacco quality measure
1. Ease of implementation
   • Will vary depending on leadership and staff support
   • Can depend on budget availability and time
   • Can be affected by regulatory reporting requirements

2. Resources needed
   • Manpower
   • Financial
   • Time

3. An organizational commitment to make to reduce harm in the use of tobacco
   • Institute a non-smoking hospital environment
   • Allocate budget for a much effective outpatient cessation program
   • Mandatory inpatient and outpatient cessation counseling to all tobacco smokers admitted to any departments in the hospital
   • Increase cessation counselors / trained tobacco specialists in hospitals

Will you/your organization join me in the journey to successfully motivate tobacco smokers to quit smoking and promote a healthy lifestyle?”
Discussion, Reflection and Next Steps

Charisse Coulombe, MS, MBA, CPHQ
Vice President, Clinical Quality | AHA/HRET
What Have We Learned?

• Change is hard but possible.
• No data = no proof of improvement.
• Barriers can be overcome - you just need to find the hospital that has done it.
• One patient harmed is one too many!
• Everyone in these projects are passionate about this work and has been inspired by a personal story which motivates them to continue the improvement.
Inspiration

Stay motivated and inspired to make change to reduce patient harm in the hospital and reduce readmissions.

– For yourself, for your family, for others and their families.
– What’s your inspiration? Chat in and tweet using #whyimhiin
Keys to Success

• Continue to
  – Ask questions of the state partners, other hospitals, the national team
  – Challenge yourselves to work on difficult topics; tell us what resources you need to help reduce patient harm and readmissions (hiin@aha.org)
  – Incorporate patients and families into all aspects of your improvement
  – Focus on safety across the board to help track your overall rates
  – Submit data!
  – Utilize the national and association resources to support your quality and patient-safety journey
  – Share your best practices with other areas of your hospital and with other hospitals across the country to accelerate and amplify the work
  – Challenge yourselves to get to zero patient safety incidents across all harm topics
Thank you for your leadership!

Next steps:

• Continue this momentum to reduce harm by 20 percent and readmissions by 12 percent by 2019.

• Thank you for your commitment, for your team’s commitment to improving patient safety within your hospital and across the country

• As with any improvement project, there are always ways to improve and spread the results

• Continue to be inspired and find motivation with each other in support this great work!
Thank you!