Inpatient Quality Reporting Program

Support Contractor

Introduction to Inpatient Quality Reporting Program Presentation Transcript

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Candace Jackson: Hello, and welcome to the Introduction to the Inpatient Quality Recording Program and Hospital Value-Based Purchasing Improvement, AHRQ PSI-90 webinar. Thank you for joining us today. My name is Candace Jackson, and I am the moderator for today's event.

This slide shows you how to use the Q&A feature for today's event. All lines are placed on mute to block out background noises. However, you can send in questions to the panelists via the Q&A feature. Follow the directions below to use the Q&A feature. Move your mouse over the WebEx navigation panel at the top of your screen. The menu will drop down. Click the Q&A icon. The Q&A

panel will display on your screen. Click the drop-down arrow next to "Ask" and select "All panelists." Type your question, and click the Send button. Your question will be viewed and addressed by a subject matter expert.

Before we begin, I'd like to make a few announcements. This program is being recorded. A transcript of today's presentation and the audio portion of today's program will be posted at QualityNet at a later date. Slides were sent out via ListServe on Friday, October 24, as both one slide per page and three slides per page. If you have not downloaded them, you can download them at our new inpatient website at www.qualityreportingcenter.com.

Today we are pleased to have guest speakers from Mathematica Policy and Research, and Bergen and Delta Regional Medical Centers.

The purpose of today's presentation is to provide a high-level overview of the IQR Program requirements and submission deadlines, address updates regarding the QualityNet Q&A tool for IQR, and provide case studies that resulted in improvement for the PSI-90 measure.

At the end of today's presentation, you will be able to meet the second quarter's 2014 submission deadline, acquire information regarding the Q&A tool, and identify interventions to improve the PSI-90 composite index rates.

For each year, to receive the full annual payment update, the hospital must be registered with QualityNet, have at least one active security administrator – and we strongly recommend that each hospital has at least two active SAs – complete the notice of participation, enter the structural measure information and DACA via the QualityNet Secure Portal, and submit the Extraordinary Circumstances form, if applicable. In addition, hospitals are required to submit clinical data for the applicable AMI, ED, IMM, heart failure, pneumonia, SCIP, stroke, and VTE measures; submit aggregate population and sample size counts for both Medicare

and non-Medicare patients; submit HCAHPS data and HAI data including *C. difficile*, CAUTI, CLABSI, healthcare personnel influenza vaccination, MRSA, and SSI abdominal hysterectomy and colon surgeries. They must display the claims-based data and the major rates on *Hospital Compare*, and if the hospital was selected for validation, the annual payment update is also dependent upon the hospital passing validation.

There are several deadlines for second quarter 2014 data submission that are rapidly approaching. On November 1, the aggregate population and sample counts are due. In addition, if your hospital has been chosen for either random or targeted validation, the validation templates are due.

November 15 is the deadline for the chart abstracted clinical process of care measures, the PC-01 web-based measure, and the HAI measures. In addition, if you intend to submit electronic clinical quality measures, the eCQMs or eMeasures, for either meaningful use or to meet the IQR requirements, those measures need to be submitted to the clinical warehouse by November 30. Just as a reminder, the submission deadline is 23:59:59 Pacific time.

We are pleased to announce that the Hospital Inpatient and Outpatient Quality Reporting Outreach and Education Support Programs Quality Reporting Center is now up and running. Here, you will find resources to assist hospitals, inpatient psychiatric facilities, PPS-exempt cancer hospitals, and ambulatory surgical centers with quality data reporting.

I would now like to introduce Cindy Cullen and Beenu Puri from Mathematica Policy Research, who are providing us with an update on the IQR inquiry backlog. Cindy, the floor is yours.

Cindy Cullen: Thanks so much. We're sorry that Kristie Baus is unable to attend this afternoon. Kristie is our project officer for the clinical quality measures project on which we're working. And I want to thank you again for your time. We are working on a project under contract to CMS to develop and maintain clinical quality measures for five of

CMS's hospital quality reporting programs. These include the Hospital Inpatient Quality Reporting Program, Outpatient Quality Reporting Program, the Ambulatory Surgical Center Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, and the Electronic Health Record Incentive Program for Eligible Hospitals, otherwise known as Meaningful Use.

Our role on this project is to develop new measures for these programs, for potential use in these programs, and to maintain the existing measures that are already in the program.

Because of the length of today's meeting, we will be unable to answer questions, but please certainly submit any questions that you may have through WebEx, and we will respond in the meeting recap that will be posted on QualityNet and on the new inpatient support website referred to earlier.

We have been working with CMS since late August to define our approach to working through and addressing the IQR inquiry backlog that's accumulated since mid-July. Our goals continue to align with CMS's goals to provide the quality of data submitted to CMS, to provide improved materials to assist with program reporting, and to provide consistent, standardized support.

We've gotten some preliminary results on our analysis of the backlog, and I'd like to introduce Beenu who will speak more about our findings and next steps. Beenu?

Beenu Puri: Thank you, Cindy. I just want to confirm if you can hear me.

Cindy Cullen: Yes, thank you.

Beenu Puri: Okay, excellent. Hi, everybody. To continue with what Cindy was discussing, we've identified some goals and how we want to help improve the questions and answers that are available to you online. So, the first step we've taken is analyzing the questions that are coming through the RightNow tool to identify these inquiries by

type, topic, and frequency of questions. Judging from these questions, there's a level of specificity that we've identified where you need additional guidance, and how to interpret particular items, and what would be beneficial to you. Therefore, we've been using the analysis of this backlog as an opportunity to identify the types of support that have been requested, and we're looking for trends by programs, by measures, by data elements, and to identify how we can better provide inquiry support.

Our preliminary findings have found that there's a growing need for clarification, proper documentation for reporting measures, additional support for EHR measures with the specifications that were written for manual abstraction, and clarification on dates and times used to report stroke measures. With this preliminary analysis, we're working with our team and CMS to devise instructive questions and answers that not only address previously submitted questions but also serve as a future reference for you when you encounter similar situations.

Of course, the ultimate source of truth for abstraction information is and will continue to be the program specifications manuals. As done in the past, we'll use your questions to help improve the clarity and the quality of the specifications manual. During the inquiry resolution, we will request input on where you find the manuals need more clarification or you've identified some confusion, and where there's a need for additional guidance. In the future, we'd also like to plan direct outreach to you through either one-on-one interviews or focus groups to gain a better understanding of how we can improve the manuals to make them simpler, easier to use, and helpful and useful for providing high-quality data. So, please stay tuned for more information on how you can contribute to this.

Finally, I want to say again that we've heard that there are some frustrations with the backlog and feedback on the recent changes we've implemented. As Cindy mentioned, we're working with CMS, and we want to ensure that we're able to provide faster and more helpful responses to your inquiries. It will take us a little time, and we appreciate your patience and feedback, and we look forward to working with you all over the next several months.

And with that, I'll turn it over to Candace.

Candace Jackson: Thank you. And now, I would like to introduce Bethany Wheeler who is the Hospital Value-Based Purchasing Program Lead. Bethany?

Bethany Wheeler: Thank you for the introduction, Candace, and I would like to welcome everyone to the first of the Hospital Value-Based Purchasing Program Improvement Series. We have selected hospitals that have shown great improvement within a measure or measure set. This month, we will be hearing from two hospitals that have shown great improvement in the AHRQ PSI-90 composite in fiscal year 2015. I recommend if you have a question for a specific hospital, that you either list the hospital you had a question for or type the speaker's name into the Q&A box. If you have a question for both hospitals, please specify both hospitals.

The AHRQ PSI-90 composite is a measure of patient safety indicators developed and maintained by the Agency for Healthcare Research and Quality, or AHRQ. CMS believes that the composite's inclusion in the Hospital Value-Based Purchasing Program is appropriate to encourage hospitals to take all possible steps to avoid threats to patient safety that may occur in an acute-care environment.

The AHRQ PSI-90 composite consists of the eight underlying indicators listed on this slide. This measure is a claims-based measure, meaning the data used for the calculations are derived from eligible Medicare claims and are not chart abstracted by a member or representative of the hospital.

The AHRQ PSI-90 composite utilizes Medicare fee-for-service patients with complete present on admission, or POA, data, excluding data from patients in Medicare Advantage plans. In order to receive a measure score for the AHRQ measure in the Hospital Value-Based Purchasing Program, a hospital must have at least three eligible cases on any one of the eight underlying indicators listed on this slide.

In fiscal year 2015 and 2016, CMS utilized Version 4.4 of the AHRQ QI software for baseline, performance, and performance standard calculations. CMS has not announced an AHRQ QI software version for fiscal year 2017; however, if a change is made to the published performance standards, an announcement with the software version and the modified performance standards will be made.

As I discuss the index values that have been achieved by the hospitals, I would like everyone to note lower values are better and indicate better quality.

At this time, it is my honor to introduce Kathleen Divers. Kathleen is Associate Vice President of the Quality and Outcomes Management Department at Bergen Regional Medical Center. She is responsible for integrating quality and patient safety initiatives across the medical center. Additionally, she oversees performance improvement, case management, and continuous survey readiness for the facility. Ms. Divers has held positions in clinical nursing, infection control and epidemiology, quality management and patient safety in New York City and surrounding areas. She holds certifications in healthcare quality, patient safety, and is a Certified Joint Commission Professional. Ms. Divers received a baccalaureate degree from St. Joseph's College and a Master's in Administrative Science from Fairleigh Dickinson University.

Bergen Regional Medical Center improved from a baseline index value of 0.602242, which is very close to the achievement threshold of 0.616248. The achievement threshold is the median of all hospital index values during the baseline period. The hospital improved to an index value of 0.466989, just shy of the benchmark value. The hospital scored a total of nine achievement points and eight improvement points. Kathleen, I would like to turn the floor over to you.

Bethany Wheeler: Kathleen, are you on? If you are on, can you turn your phone off of mute? If not, Deb, can we advance the slides to our next hospital presenter, and we can check back with Kathleen after Delta has presented?

Our next speaker is Angela Parkinson. Angela Parkinson is the Director of Quality for Delta Regional Medical Center, located in the Mississippi Delta. Angie is a Bachelor's-prepared Registered Nurse. As the Director of Quality, her purview includes regulatory compliance, patient safety, core measures, meaningful use, risk management, EMR engagement, education and other applicable quality initiatives. Angie is a 22-year veteran of Delta Regional Medical Center, having spent the majority of her tenure in its busy emergency department, where she still works occasional weekends to keep her current with practices.

After several successful Joint Commission Surveys, she has transitioned her facility from The Joint Commission Accreditation to a CMS Certification Survey process. She has also led the facility to successfully attest to a full year of Stage 1 Meaningful Use.

While not working to improve the quality of care delivered at Delta, Angie enjoys time with her family. She is married to a supportive husband and has two beautiful and active school-age daughters. She is also enrolled in the Doctorate of Nursing Practice program at the University of South Alabama in Mobile. With spare time at a premium, Angie enjoys sneaking off for a long run with several running partners when she can.

Delta Regional Medical Center improved from a baseline index value of 0.541199 to a performance index value of 0.430568, which is better than the benchmark value, which is the mean of the top 10%. The hospital received 10 achievement points and 9 improvement points. Angela, I would like to turn the floor over to you.

Angela Parkinson: Good afternoon. Thank you. I hope not to bore anyone this afternoon, and hopefully you didn't have a very big lunch to make you very somnolent this evening. We'll start with Delta and our path to improving.

A little bit about Delta Regional Medical Center is that we're licensed for 325, we're located in the Tri-Delta area of Mississippi,

Arkansas, Louisiana. We are just across the bridge from where Arkansas and Louisiana state borders meet. We are a full service, non-for-profit facility. Our payment structure is about 76% Medicare-Medicaid, 12% commercial and 12% self-pay, so we're pretty heavy on the underinsured population. Our services include medical, surgical, obstetrical, critical care, psychological, emergency services, rehabilitative, cardiac care, laboratory, radiology, outpatient, and nuclear medicine.

Where we began; PSI-90 is created of eight metrics. When we started looking at our PSI-90 scores and how we were planning to improve them, we really decided to focus on those scores that we felt we had the largest opportunity to improve upon. We started there by selecting the four that we felt we had the most opportunity to gain, and then we selected our teams based on which measure we would be working on, so that we could include the applicable staff, front line staff, leadership, physicians and physician leadership, and administrative pieces, as not to overburden anyone.

We also then reviewed our performance improvement process. We wanted to make sure that everyone understood how to standardize their actions so that in the end, everyone was doing the same thing. Standardization is where you get the biggest benefit when you're working to improve on a project. We reviewed the data and data reconciliation – what were the data telling us, what impacted the data, what barriers were there that caused the staff not to be able to meet the measure, or that prevented the staff from meeting the measure as quickly as we would have liked, and an assessment of organizational readiness for change, leadership support, and then how do we get there.

So, our first determination was to decide what metrics to work on, then to structure our teams based on the metric, and then to choose the path on how we were going to get from where we were to where we wanted to be with each of the metrics.

So, the first step was choosing to eat our elephant one bite at a time. PSI-90 is a huge measure if you look at it in its entirety. There

are a lot of moving parts and components. We opted to work on the four components of PSI-3 Pressure Ulcer Rate, PSI-7 Central Venous Catheter-Related Bloodstream Infections, PSI-12 Postop DVT Rate, and PSI-13 Postop Sepsis Rate.

How to get to where we needed to be was again a process of teaching everyone to standardize what we were doing, where we were starting. So, we fell back to our process improvement practice of plan-do-check-act, or PDCA. We consistently use that process with all of the team meetings and with all of the staff to ensure that everyone understood where we were with each step of the project.

Process changes; for PSI-3, Pressure Ulcer Rates – as with any project, you really have to start with where you are, and where your barriers are. So, we started with the review of the current processes, looking at our process for pressure ulcer identification, for treatment and reporting of the pressure ulcers. We found a huge gap in reporting. The staff may document it in the medical record, we had issues varying from completion of the documentation to completion of notification, we use in an event reporting system to monitor our pressure ulcers, because all of that filtered back to the quality office. We found that they were not being completed properly. They were getting lost in the nurses' station; sometimes they didn't make it to the director. So, we really worked to clean up the event reporting process, inside of reporting on pressure ulcers.

In 2011, we enrolled in Hill-Rom's International Pressure Ulcer Prevalence Survey, or IPUP Survey. We've participated every year since then, but this is our inaugural year to participate in the IPUP Survey. We garnered a lot of very useful, real-time information on the pressure ulcer prevalence rate and issues that were impacting our staff and barriers that they had at the bedside.

We also reviewed and made changes to our skin products, patient surfaces, and incontinence products. As we began to work on the pressure ulcer rate, it really unfolded into a much larger project than we had initially anticipated. We knew that we had some reporting issues, and maybe not everyone was measuring an ulcer the same way. However, what we began to uncover as the staff brought their

barriers to us, and we really began to in earnest look at them, were that we had opportunities for improvement in our skin care products. We ended up scratching what we were using and going with a complete start-to-finish product line by one of our vendors, so that that includes the foam cleanser, the barrier, the lotion, the wipes, everything that is married together in order to provide the best outcome for the patient.

Patient surfaces; we began discussions – we found a sundry of issues with our patient surfaces. We were still using some egg crates, we were still using baby powder, things of that nature that we really started to look at and take them out of our supply rooms altogether, so that they're not even available for the staff to use. Then we ended up purchasing I think it was 120 new inpatient beds. We really felt that it was time to upgrade our beds, and this was a good springboard for us, because we had collected a good bit of data that led us back to our patient surfaces.

And then incontinence products, every – it's the nature of health care to have patients who are incontinent for a large number of reasons. One thing that we went back to that really has impacted our care at the bedside are the blue pads or chucks or every facility calls them a little something different. The under-patient pads, we were using a product that was really inferior, and it was not helping our patients nor was it beneficial to our staff, because they were working twice as hard to get things accomplished. So, we ended up changing a number of things in our product lineup.

Everything said, we had decided on a standardized process for identification, treatment, documentation, our lineup of products. Then we began education, and it was educate, educate, educate, for around a month, three to four times a week. We would have classes that every nurse was required to attend, and we would go through with the help of our vendors, we would go through scenarios and processes and our new products, and it was a see-feel-touch; we didn't taste anything, however. Just what the products feel like, how they're going to feel on the patient's skin, how much Diet Coke does this under-patient pad hold, that kind of thing to really engage them into the learning process.

We also took the opportunity to really hone in with them the communication piece. The CNA is as important as the nurse is as important as the team leader, on up the chain, in identifying and helping prevent or treat pressure ulcers. So, we really tried to break down the silos and promote teamwork in that process so that everyone understood their part of the team, and where they could improve the patients' outcome. And then of course, we followed that up with follow-up and reassessment, and we turned those numbers back around to our staff on a regular basis.

PSI-7, or Central Venous Catheter-related Bloodstream-Associated Infection Rate; this is something that is still a work in progress for us. We started, however, when we were working on our PSI-90 scores, with a review of the current processes for insertion and care and maintenance. We also reviewed the supplies and products that we had in use there. What we did end up doing there is to marry some new supplies and some additional supplies in the processes for insertion care and maintenance of the central venous catheter. We found that we had a couple of different policies. We had one that pertained to multi-lumen CVCs; we had one that pertained to PICC lines; we had one that pertained to ART lines. So, we really standardized everything, put it back in together, and made one policy that addresses the insertion, care, and maintenance of all CVCs. We then reviewed our supplies; we found five or six different trays, central line trays that the physicians were using for insertion. One physician may prefer one in the surgical setting, another may prefer one in the ICU setting, and then the ED was using two different ones, just whichever one came to their hand first.

So, we took that opportunity and cleaned up our supplies, so again we standardized that process for the staff so that when that kit comes out, there's one tray, one bundle, and everything is the same regardless of location. We also added in central venous catheter PI monitor, which we have found useful. I'm pretty sure that we're not the only facility that struggled with some of the older physicians starting to dress out completely to insert a central line when they had not been doing that for 30 years. We use the central venous catheter PI monitor as that communication tool back to the quality department and the infectious disease department, so that

we can look at those and have conversations one-to-one with those physicians who are quite bought in on using the entire central line bundle. That prevents the staff or the nurse at the bedside from having to have that strict discussion with the physician in front of the patient.

Again, once we had everything in a standardized process that we were going to use as a facility, we began the education process. We educated front door to back door, physicians and nurses, using our vendors and some subject matter experts on the topic. We follow up with our staff regularly and reassess where we are. These numbers are also rolled back to our staff currently on a monthly basis for the central venous catheter-related bloodstream infections.

PSI-12 is Postoperative Pulmonary Embolism or Deep Vein Thrombosis. The issue that our facility had there was not with the pulmonary embolism, but more so with deep vein thromboses. What we started with was the review of the current processes for intra-operative and postoperative care of the patients and the review of data per surgeon. We started with the patients who had had any issues, and then we really dug backwards into their records to see where there may have been an opportunity.

We standardized things using power plans, but one thing that we found with the power plans is that some of the orders were not firing for that patient's step in the process. So, by working with the physicians and reviewing their data one-to-one with them and really looking at where the orders were firing for them, we were able to improve those power plans and move things around to fire at the appropriate time per patient, and also to allow us to turn around and give those surgeons real time data on the back end.

One-to-one conversations with the surgeons, we carried those out in private so that we could really have an earnest discussion with them on where we found a hiccup in the care that was delivered, and where they felt that hiccup may have come from. Again, once we had everything standardized we were ready to roll; we knew where everybody was going to be. Then we began the education

process with the surgeons and the nursing staff. And follow-up and reassessment, follow-through, we also used the core measure VTE process and the company I met with this said that we are able to really keep that conversation at the forefront with our physicians and nursing staff.

The last one we'll discuss is the PSI-13, Postoperative Sepsis Rate. We began looking at our PSI-13 data based on the intra-operative and postoperative antibiotic selection, and of course, those numbers were more readily available to us from the core measures SCIP project. So, we began looking at these, and then having the conversations with the surgeons one-on-one, and then that moved us back into having conversations with the anesthesiologist based on the workflow in the intra-operative area.

We worked to standardize the treatment with core measures, recommendations, again with the power plans that we have in place, and our electronic medical record, and making sure – really looking at those orders and making sure they're firing at the appropriate step. We ended up having to take a couple of the order sets or power plans and break them into smaller components that are fired based on the patient's movement in the peri-operative cycle with pre-op, intra-operative, and then postoperative care.

We then took all of the information that we had gained from reviewing particular records with each physician and had those conversations with them on where we had opportunities for improvement. Again, we provide constant follow-up and re-assessment of these scores and of these projects so that we can have this information available for the physicians and the nursing staff in real time.

Global process changes were those changes that were not specific to each or to a single metric that we worked on, but that really were applicable house-wide to something that we've worked on throughout many years, which is communication. We had a creation of Special Topic Task Forces. All of these task forces related to each one of these metrics were of very short duration. They were short meetings, 30-45 minutes, but they also went for a

short period of time such as three months. We really wanted to focus these Special Topic Task Forces on rapid cycle change. We want to identify the barrier, we want to work on the barrier, and then we want to move on.

We didn't want to keep the staff tied up in repetitive meetings that eventually become inconsequential to them, so we really wanted to keep them front of mind and keep them engaged in the process. So, we kept it very quick, short meetings, and then the duration was very short as well.

Inclusion of the data into the Patient Safety Committee – all of the previously discussed data was included into our Patient Safety Committee so that it was discussed in a full house forum – not a full house forum, but in an interdisciplinary forum to allow everyone to understand where our focuses were and what we were working on. If you had a piece of the puzzle or if you were working in the process with us, you were already aware, but others needed to be aware as well.

Weekly Core Measures/Quality meetings with all directors present – this is probably my favorite meeting at our facility, and I'm sure everyone gets into that meeting overload. This meeting is once a week. It's every Tuesday at 2:00 p.m. It has been since Noah built the ark, 2:00 p.m. on Tuesdays is Core Measures. All of the directors know, they all participate, they all show up, we have nursing administration, quality leadership, and then we have all of the directors for inpatient and outpatient services who are there. We review things such as our core measure scores, we review items such as these with PSI-90, we also go over a number of in-house audits that we do, and we probably as a group learn more from each other in this meeting than any other venue we have at our facility.

We also review all outlier cases. These are cases that the quality instructors may find that are outside of the norm or outside of our personal targets. Once we have identified an outlier case, the abstracting tech staff would then begin accumulating a document or a record on these patients, and then we will sit down together and

go over them. Myself, as the Director of Quality, and then the director of the unit, and then any staff who was involved or identified to have been involved, we will all sit down and talk about, discuss, and look at it in a non-punitive fashion, to figure out where we can go with it. How can we remove barriers, why couldn't you meet the need of this patient, or why do we have an opportunity here. We really want to mitigate these opportunities and turn them into wins for our staff.

Open discussions with staff and physicians related to outlier cases. Again, going back to the one-to-one discussions with the physicians, we still have those discussions when a patient becomes an outlier case, and we take those cases back to the physician specific to that case and have a discussion with them, go over the opportunities for improvement, where could we have made this better, how could we have helped you, was there a barrier? Did something not work properly? Did you have to revert to paper orders versus CPOE? We work through all of those issues with them on a one-to-one basis.

And then, re-education of the staff ongoing with each outlier; just as with the physicians, the nursing staff, we meet with them. We go over why did we not meet the needs of the patient, where could we have improved this, they give us great feedback. They give us all of those things that when you're not practicing at the bedside, you forget, or you don't realize, or you put three extra steps in and only have time for one. So, by taking this information back to that staff who's from the bedside, we're able to improve our processes and really mitigate barriers that may be across the continuum, but we're only seeing them in one particular area. .

Oh, and we're at the end. Thank you very much.

Bethany Wheeler: Thank you for that presentation, Angela. Can I ask if Kathleen is on the line, now?

Kathleen Divers: I hope I'm back on the line; can you hear me?

Bethany Wheeler: Yes, I can hear you now.

Kathleen Divers: Oh, that's wonderful.

Bethany Wheeler: Deb, can you go back to the beginning of Bergen's presentation, and I will do a brief introduction for Kathleen before I turn it over.

Kathleen Divers is Associate Vice President of the Quality and Outcomes Management Department at Bergen Regional Medical Center. She is responsible for integrating quality and patient safety initiatives across the medical center. Additionally, she oversees performance improvement, case management, and continuous survey readiness for the facility. Kathleen, I would like to turn over the floor to you.

Kathleen Divers: Thank you very much.

This is just our goals and objectives, where we just hope to share our PSI-90 score improvement with everybody out there.

A little bit about Bergen Regional. We provide comprehensive, long-term behavioral health and acute medical services. We are the safety net provider for the mentally impaired, elderly and uninsured and underinsured in this area. And, we are the largest hospital in New Jersey with 1,070 beds.

We are a New Jersey-HEN Mentor Hospital, we're a NICHE hospital, we've received recognition from NJHA for our TCAB program, and the long-term division is a winner of the New Jersey BIZ Nursing Care Center of the Year award.

We are located in Paramus, New Jersey, which is a suburb about 15 miles right outside of New York City. Next.

And again, it was explained already what the PSI-90 score is; it's derived from eight patient safety indicators. Next, please.

Okay, so we thought when it came to PSI-90, that we had everything in place. PSI-3, which is Pressure Ulcer Rate, we had a very active skincare team. For PSI-6, Pneumothorax Rate, we did MD training, we had site identification, and we had a full program there. Same thing with Central Line infections, we had implemented the full Central Line Bundle. With postop hip fractures, we had a very aggressive fall prevention program, in all areas of the hospital. Next.

For postop pulmonary embolism and DVT, we had implemented a full prevention program. Postop sepsis, we did pre-op screening, we did early mobilization, we have a very strict antibiotic stewardship program run by our Director of Infectious Diseases. And we thought we had it all in place there. Same thing with postop wound dehiscence, we had a full patient education program that began actually at the time the patient booked the surgery. We did nutritional assessments, glycemic control, we have a stringent OPP and FPP process, and yet we weren't seeing much improvement.

For PSI-15, accidental puncture, again we had a great deal of staff training, OPP/EPP/FPP, all those PPs, and we had very many OR safety measures.

Additionally, we had many global safety measures in place. Every surgical patient is followed by a Hospitalist, so they are closely monitored for any postop complications. As I mentioned before, we had a peri-op patient education program, we were a HEN participant, we were also very involved with the SCIP project, we had procedure-specific protocols, we had peri-op checklists, and we had CPOE fully implemented. Next.

And with all that in place, we still weren't moving some of these indicators, so we had to take a good look at ourselves. Next.

We took AHRQ's advice, and we did a Patient Safety Culture Survey, and our results really surprised us. Next.

The most concerning scores we found were that staff tells they did not support one another, that mistakes were held against the staff by management, and staff said they were afraid to ask questions. So, we knew it was time for action here.

We developed and implemented a dynamic program that was put into place to improve both teamwork and our safety culture. Next

The first thing we did was work on teamwork. We had a teambuilding month where we did formal education on teambuilding, we sent out daily teambuilding tidbits – e-mails to everyone. We had teamwork presentations in our employee newsletter; we put up posters all around the Medical Center. Basically, there was nowhere you went during Team Building Month that you didn't hear something about team. Next, please.

So then, we decided to put all these skills and apply them in a practical matter, and we held a series of teambuilding fairs. Next, please.

And this is just a picture of some of our staff enjoying our teambuilding fairs. Next.

The activities we had at our teambuilding fairs were Team Bingo, a team – and we had people from the same departments on teams, and then we split them up and made them work with people from different departments. So, we had Team Bingo, where they had to complete a bingo card. We had Tower Building where a team had to build the highest tower and they won a present. We had Pass the Egg, which is how many times the team can pass the egg without dropping it; our housekeeping department was very happy with that activity. They won a prize. Then we had them spell "team," when each person came into the fair, they were given a letter, either a T, an E, an A or an M, and they had to walk around the fair and find somebody with the other three letters to complete "team."

This was our favorite activity; this was Pin the Moustache on our Chief Medical Officer. And this was just our take on the old pin the

tail on the donkey game. We had a team, we had one member blindfolded, and the other members had to direct the blindfolded person to pin the moustache in the correct place. And our CMO, lending his support for this, was just – it just showed his total support for our activities, and that proved invaluable. Next, please?

And then, after working on teambuilding, we decided to attempt to build a culture of safety. Next.

We enlisted leadership support, which we were very successful with. They gave us funds to hire a Patient Safety Officer; they gave us other resources, basically money, to pay for our [inaudible] activities. They do see – we have Senior Staff Rounds, this is probably the only hospital where many of our patients know the vice president's first name. Often times you hear many residents say, "Hi, Katie," to our long-term care administrator, and "Hi, Tom," to our behavioral health vice president.

We have senior staff members on our Patient Safety Committee, several vice presidents; also, our medical director of psychiatry is very active. Safety agenda items are on every staff agenda. We had a lot of PR support. They gave us a lot of printing of materials, making posters, and of course lending some creative help on our projects. The hospital paid for our NPSF, National Patient Safety Foundation, membership, and of course they made our #1 priority safety.

We also worked on communication. The quality department started their own newsletter. We called it, "Eyes on Quality," and in that it's filled with all sorts of articles that tell staff how they can improve patient safety. Each month, we have an employee newsletter, and each edition of that also has information on patient safety.

We occasionally put in paycheck inserts, so when somebody opens up their paycheck, they get a message about patient safety. We instituted a new process called "Ticket to Ride" for ancillary handoffs. We thought we were pretty good with handoffs between clinical people, but we were a little concerned about when transport

hands off to another department, so we developed a process called, "Ticket to Ride."

We made educational videos, which starred staff. We did one on hand washing, which included everyone from the CEO to nursing to housekeeping to facilities, of them washing their hands. We recently did another one on noise reduction, where we had every – many staff members going, "Shhhh," to the background of lullaby, and that was very well-received. We also have a project we call, "Answer a Question, Get a Treat." We, members of the Quality and Safety department, go from department to department and they ask a safety question. And if the person gets it right, they either get a candy bar or if they're watching their diet, we give them an apple.

And then, we came up with the Good Catch Award, because staff said they were hesitant to report things. We made it profitable for them to report things. All staff got involved by reporting near misses, or what we refer to as a good catch. We get small gifts, usually little gift cards, to the employee who comes up with the best good catch story in various time frames, and that greatly increases the number of near misses. We never got near misses reported until we instituted this project. Next, please.

And then following on the success of our teambuilding fair, we held a series of patient safety fairs. Next. Next, please.

And our patient safety fairs, we had interactive activities for both clinical and non-clinical staff to participate. We had one booth that was, "What was wrong with Sam?" We had a patient room set up, and we had things that were wrong with that patient room. Sam was smoking a cigar, he was on oxygen, he had one arm restrained to a side rail, I believe there was a puddle of water there, and staff had to give as many wrong things that they can, and if they came up with them all, they got a prize.

We had, "Get Charlie Out of the Hospital," which was a board game, which you rolled the dice and you made various steps trying to get Charlie out of the hospital, but you had to go back step for

such things as, Charlie fell out of bed and broke his hip, Charlie developed *C. diff*, and other common complications that hospital patients get while in the hospital.

We had the Purple People Eaters, or PPE. This is where we had staff members dress as MRSA or TB, and the staff members participating in the fair had to say what kind of personal protective equipment they would wear if they met this organism in their work.

And then, we had Safety Jeopardy and Wheel of Safety, which was basically staff won prizes by answering safety questions. Next, please.

And then we gave some positive reinforcement. We recognized people for a job well done. We invented what's known as the Quality and Patient Safety Cup here; you can see it in the pictures, it's a big gold cup, and it recognizes areas of the medical center that consistently provide a high quality patient care and patient safety. Today, we've had the emergency room has won the award, our ventilator unit has won the award, and our infection control department also won the award. Next, please.

So, it's been a long road. We still have far to go; however, we have realized an improved culture of safety, which in turn has created a safer environment for our patients. Next.

And, that's all I have.

Candace Jackson: We'd like to thank Angela and Kathleen for presenting their success stories to us today. We now have an online CE, Certificate process. There are two methods for receiving your CEs.

If you registered for this webinar through WebEx, you will receive your survey within 48 hours. If you are attending the webinar as a group, please forward the survey to other attendees. In order to receive your CE certificate, you will need to complete the WebEx survey. At the end of the survey, click "Done," which takes you to a page where you indicate whether you are a new user or an existing

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Once you have registered into the learning management center, you will not have to register again for any of our events.

This program has been approved for one CE for the boards listed on this slide.

And now, Bethany and I will go over a few of the questions that have come in during the presentation.

For the IQR requirements, I have the following question. First question: when do the structural measures and DACA need to be submitted? The submission period for Fiscal Year 2015, which included January 1 through December 31, 2013 discharges, was from April 1 through May 15 of 2014. You will not be required to submit again until April 1, 2015, for Fiscal Year 2016, which will be for January 1 through December 31, 2014 discharge quarters.

Second question: how often do we submit the healthcare personnel influenza vaccination measure? Submission is done only once a year. For fiscal year 2016, which was fourth quarter '13 through first quarter '14 discharges, the deadline was May 15 of 2014. The next deadline will not be until May 15, 2015, which will be for fiscal year 2017, covering fourth quarter '14 through first quarter '15 discharges.

Next question: when should data be submitted to the clinical warehouse? The best practice is to submit early and often. You need to allow ample time, at least 10 calendar days, prior to the submission deadline to ensure that your data have been submitted and accepted. In addition, this allows time to correct any problems identified from the review of the provider participation report and other feedback reports. Additionally, as best practice, if your vendor submits the data on your behalf, you still need to review the data and the reports to ensure that they are accurate and you have met all the IQR requirements.

And the last question I have is: when will the addendum for the January 1, 2015 specifications manual be posted to QualityNet? And the manual, which will cover first quarter '15 through third quarter '15 discharges, will be posted to QualityNet October 31, 2015. Bethany, do you have any questions that you would like to address at this time?

Bethany Wheeler: I do; thank you, Candace. We have received some questions for these hospitals, but I would like to remind everyone that if you do have a question for these hospitals, we are still accepting them through the Q&A box. Please, if you have a question for a specific hospital, list either Bergen or Delta, or the speaker name, Angela with Delta and Kathleen with Bergen. With that being said, I will go to the first question.

And, it is for Angela: who are the members or attendees of your Patient Safety Committee?

Angela Parkinson: Thank you. Our Patient Safety Committee is made up of an interdisciplinary group that contains our front line, some front line staff, director staff is involved, quality, nursing administration, senior administration, and then the information from there is rolled to our quality committee, which has physician participation at that level. We also share a staff with laboratory, radiology, and several other therapies involved in that committee.

Bethany Wheeler: Thank you, Angela. The next question is also for you. Was a particular surgery associated with more of your PSI-12 events? If so, were you already using best practices, or did you need to identify and encourage use of best practices?

Angela Parkinson: Thank you. We did identify one surgical procedure that had more prevalence in the PSI-12 category. We identified that that particular surgeon had some ambiguities in how his orders were firing. Once we were able to determine the issue and correct the firing of those orders at the needed step in the patient's process, then we were able to clean up that process for him, and we've not had any associated with that recently.

Bethany Wheeler: Thank you for that example. This is for both of you, but I'll let Angela answer first: do you do concurrent coding at your facility? What is a best practice with this process that you have identified?

Angela Parkinson: Thank you. Yes, ma'am, we do concurrent coding. Our quality abstractors start every morning, every business morning, looking at the current patient census and any admits that were completed prior to the last business day. We have a report that runs through our EMR that allows us to pull just those patients. So, they're able to look at the patient admit list fresh for the day, review their reasons for admission, and cast a very large net. Then once the nurse coder, usually in the first 24 hours when the nurse coder has seen, has reviewed the patient's record and placed some tentative coding information in there, they're able to cut down a really narrow – their depth of their abstraction then, and finally once the patient is discharged and final coded, then they're able to take some additional patients off of their record. They're pretty competent at their job and really able to look at those patients, usually for the first time – from the first time, and determine if they really fall into our population or not. So, we do try to do concurrent coding. I mean, concurrent abstraction, with coding.

Bethany Wheeler: Thank you, Angela. Do you have anything to add, Kathleen?

Kathleen Divers: No, ours, we're somewhat similar. We do have clinical documentation specialists, and they work very closely with the medical records department, so they're doing concurrent coding and then they continue to work with medical records until final coding is done.

Bethany Wheeler: Thank you. The next question is for Kathleen. How did you roll out the Good Catch Award, and what criteria is used to determine the best good catch?

Kathleen Divers: Okay. We rolled it out – well, not that we rolled it out slowly, but response was very slow. We had to keep on pushing it, pushing it with the staff, pushing it with the managers. Finally, after we got a few submissions and we gave awards, the first few were not really

big deals. But, just to get the sort of marketing out there, get people's pictures in our newsletters, then slowly but surely more important near misses were reported. And now, I think we have kind of an active program.

As far as picking the best, it's done by the Patient Safety Committee. We just picked who we think is the most significant, the one who had the most significant impact on patient care. And we try to recognize mostly everyone; we give them a little trinket, because it is a big change in our culture that's being exhibited by near misses.

Bethany Wheeler: Great, thank you. Our next question is for Angela. What data did you provide to surgeons? Did you get pushback from the surgeons who are not performing as well?

Angela Parkinson: Thank you. As with any physician specialty, you're apt to get a little pushback if you're bringing to them information that they don't readily want to see. The information that we provided to the surgeons or to any physician is information that is specific to that physician. It has been vetted through at least two experienced nurses, sometimes peer reviewed, depending on the position.

Once we had begun the process of presenting this information to them, and can bring back to them the evidenced-base practice they should be following with their – when they would give us a reason or a barrier. Then after about a year or six months, depending on the physician, they really started to accept what we were saying from a quality standpoint as always being backed by evidence, so we built a little trust there with some of the physicians.

Some take a little longer than others, but really if you standardize how you're presenting the information to them and always have the evidence behind you to support what you're telling them should be done, generally it may be a little repetitive for some. But eventually they catch on, and they'll start to follow in suit with their peers.

Bethany Wheeler: Thank you for that answer, Angela. This question is for both of you. What is your best suggestion for hospitals trying to improve their PSI-90 rates? Do you have an example for providers that are just starting to look at improvement? And I will let Kathleen take this question first.

Kathleen Divers: I think you probably have to look at each individual indicator separate. See if you have things in place. If they are, and they're not being effective, then I guess you have to take the approach that we did here at Bergen and change the culture. Get people to take those checklists seriously, to follow the standards, to report when there's a problem, so as I say – I think you have to see this, you have things in place, and once you have things in place if you're still not seeing improvement then you have to go to the next step and figure out why you're not seeing improvement.

Bethany Wheeler: Okay, thank you. Angela, do you have anything to add?

Angela Parkinson: No, I pretty much mirror with Kathleen says, and you have to remember to get your front line staff involved. If you have processes in place that from your perspective should work and improve a process, and you're not impacting any change, you need to look and see where the barriers or the bottlenecks are, that are preventing the staff from accomplishing what you thought was able to be accomplished.

So really, take that back to the hands-on staff and let them be the people who mold that process. You sometimes have to give them a little guidance of why you need it done a certain way, but it's always better to put that back in the staff's hands because they're going to know their workload better than anyone else.

Bethany Wheeler: Thank you, Angela.

The next question is also for both of you. The question is: are you planning on changing your core measure review process, with the decrease in measures and the weighted change in value-based purchasing? We are concerned about dropping compliance and

care with measures being dropped, and I think to speak to this question, the more I think the questioner is referring to in Fiscal Year 2016 and Fiscal Year 2017, there were some clinical process of care measures that were removed from the program, and the weighting has increased to incentives other measures and domains within the program, one being the Outcome Domain or safety measure, containing the AHRQ PSI-90 metric.

So, Angela, I think I'll let you answer that one first.

Angela Parkinson: Thank you. We have restructured our reporting. However, we are not planning to restructure our data abstraction. We too feel that if we really allow that to fall by the wayside, we'll see an impact to the care delivered to the patient there, so for the next six to 12 months, we'll keep our original abstractions and add to them, paying more focus to those things that are going to be restructured and calculated in the value-based purchasing. However, we're not quite ready to let go of those other measures just yet, until we really know for sure and feel confident that the staff and the physicians have a grasp on that.

Kathleen Divers: Yes, and at Bergen we're also continuing to collect those data. We saw a little falloff in our core measures when we moved to an electronic medical record. So, we very much have to continue to pursue those that are going away, so to speak.

Bethany Wheeler: Thank you for your responses to that question. The next question is for Angela. What were some of the standardizations that you focused on?

Angela Parkinson: Thank you. We really looked at each and every metric as a blank sheet of paper. Where are we, and who was doing what. Oftentimes we have found that when you're not paying attention or really comparing the units or the staff across the board, you'll find pockets of people performing well, and then pockets of those who are doing things maybe a different way or they didn't realize there was a change. So, we really looked at each process individually, and from front to back, from the time the patient is received from

the nurse, try to standardize those processes – the process for pressure ulcers, one of the key things we standardized was assessing the stage of the pressure ulcer. That's very subjective, based on a nurse's education and background, as to how well they do that.

So, we really tried to provide them with the tools they needed to be able to assess that wound and assign a stage and a standardized process, so that two nurses on different shifts came up with the same answer; things of that nature.

We really try to standardize pulling forward from the patient's arrival, and keep everything in line. And it's – as facilities, we oftentimes think that oh, we've got that, it's easy, no problem; we've got that down. Until you really start to look at your data and where you have opportunities, that's generally where you start to see there's some variation, there's someone stepping away from standard and doing their own thing, and they think they're doing the best thing for the patient because it makes sense to them. It's all in the staff knowing why. Why I have to do it in these many steps, or why I need to do this before I do the next thing. So, addressing the why will really help you standardize front-to-back the care that you're delivering.

Bethany Wheeler: Thank you. I think that was a great example. The next question is for both of you again. How big is the quality department, and what roles are included in that department? Kathleen, do you want to start off?

Kathleen Divers: Oh, well, we have about 25 employees. Not all of them are doing quality per se. That includes 14 case managers, an appeals coordinator, several people like that. I would have to say for quality per se, we only have about five to six people. Five-and-a-half, we have a part-timer.

Bethany Wheeler: Thank you. Angela?

Kathleen Divers: You really have to strive; because we are so large with over 1,000 beds, we really strive to bring in staff people to help us, because we couldn't possibly do the job all by ourselves.

Bethany Wheeler: Thank you. Angela, what about your hospital?

Angela Parkinson: Right. Well, at Delta, we're only about 325 beds, so if you look at us compared to Kathleen, we're probably going to be just about in line. I'm the Director of Quality, and I have two core measure or quality abstractors who work under me. But, as Kathleen said, if it weren't for the team really helping out, the directors really being engaged, those Tuesday 2:00 meetings, I know that when I go to those meetings, they're going to give me work to do but they know that I'm also going to be asking questions and really looking to see where we're going from a quality perspective. They will also, they will keep things and bring them out in the core measure meeting just so that everyone around the table can have a discussion. The Med-Surg, Neuro, Nurse Manager, will wait until we're in that venue. She may have discussed something with me previously, but she'll wait until that venue really to vet it among her peers.

So, we have a smaller department here at Delta, but it really is a team effort here to make sure we're all on board with delivering the highest quality care we can for our patients.

Bethany Wheeler: Thank you. The next question is for Kathleen. Were there metrics outside of the PSI measures that were used to identify which of the organizational culture improvement efforts were most effective?

Kathleen Divers: Well, of course we did use the AHRQ survey that we originally gave and found our issues. We resubmitted that to our employees, and we did find quite an improvement after all our activities. And of course, we looked at all our patient safety indicators – fall rate, we have a very big behavioral health department, we have over 324 behavioral health beds, so violence is very important to us. So, anything that had to do with patient safety, we watch that very carefully to see if our activities were impacting it.

Bethany Wheeler: Thank you. The next question is also for you, Kathleen.

Kathleen Divers: Okay.

Bethany Wheeler: Did your organization retake the safety culture survey yet? I'm curious whether the scores on that survey improved along with the PSI-90 index.

Kathleen Divers: Yes, as I said in the previous question, we did redo the survey, and we did see improvements, particularly in the three indicators that we were focusing on.

Bethany Wheeler: Right. The next question doesn't specify who it's for, so I'll take that as for both. Did you work with your coding specialist regarding accidental operation laceration? Kathleen, I'll let you take that one first.

Kathleen Divers: Well, we get a listing from our medical records department, from the coders, of all these complications that are included. So, we do review them, and if we have an issue, we will discuss it with the coders. But they're pretty good; I don't think we had too many questionable codings.

Bethany Wheeler: Thank you. Angela, can you answer that question as well?

Angela Parkinson: Sure. We do work, our quality abstractors do work with our coding staff. If we see there's a potential mismatch in what is coded in the data, that the quality abstractor feels is present, we're very fortunate to have two quality abstractors who are HIM-trained. They came to our department from a long history of being in HIM, either coding or doing general HIM work. So, we're fortunate that they know the staff who's working in HIM currently and that they're comfortable enough in their assessment skills of the record to know whether or not that truly should have been coded in that method.

Bethany Wheeler: Thank you. And I would like to remind everyone that if you do have a question for one of these hospitals, please do submit the question through the Q&A tool. We have two questions left unless we

receive any more questions. With that being said, the second to the last question: we are having issues with compression devices documentation and usage. Does anyone place sequential compression devices on all patients? Angela, I'll let you take that one first.

Angela Parkinson: Gosh, that's a great question, and it's a struggle for us as well. We do have an electronic medical record that is whole-house, so we have the opportunity for the consistency there. We do not place SCDs on every patient. We do allow the physician the options of TED or SCDs, or graduated compression stockings or the SCDs, in their power plans. So, they can select in the power plans which they prefer. One thing that we do often run out of are the number of SCD devices needed to meet the demand, and so if all SCD devices are in use, we do fall back to the graduated compression stockings, if it's applicable for the patient. So, we do – I understand that frustration with SCDs and graduated compression stockings, but I don't know that it's reasonable to place SCDs on every patient who comes into the facility. It wasn't for us, anyway.

Kathleen Divers: Yes, we also don't require them on all patients. We did run into some problems with nursing documentation with it. It is on our electronic medical record, and it took a lot of reinforcement to get the nursing staff to remember to document when they were on patients. But no, we don't require them on all patients.

Bethany Wheeler: Thank you. The next question is also for both of you. Could either of the hospitals use the AHRQ tool kit to help with improvement? If so, how? Kathleen, do you want to take that one first?

Kathleen Divers: I'm sorry, I didn't hear the first part, the AHRQ what?

Bethany Wheeler: The AHRQ tool kit to help with improvement.

Kathleen Divers: Well, obviously we use their survey, and we did use their tool kit. They give suggestions on how to improve things, so we actually used that to make sure that we had all the improvement activities in place.

Bethany Wheeler: Thank you. Angela?

Angela Parkinson: We did use the AHRQ tool kit as a reference guide, or as a resource, while looking at our improvements. We also have a partnership with a third party company that's wonderful with resources, that also allowed us to use some blueprints that they had in order to really mirror and look at our practices and how we could improve there.

Bethany Wheeler: Thank you, and we did have one more question come in. Do either of you have a best practice alert incorporated in electronic medical record for sepsis? Angela, do you want to take that one?

Angela Parkinson: You know, I would love to have one. I was hoping you were going to ask about VTE and DBTs and things, because we do have an alert that fires to the physician based on those. But, sepsis is – we have worked on sepsis as an alert system within the electronic medical record, and it is one of those rules or custom builds that is so monstrous, it takes a while to get it right. We are working towards it, but we don't have it operational yet.

Kathleen Divers: And at Bergen, we're kind of in the same place. We would love to have it, but I know our IT people are having difficulty building them. They evidently are very tedious on the IT side. So, hopefully someday we'll be able to say that.

Bethany Wheeler: Thank you, and that is all of the questions that we have received so far. And to anyone who hasn't submitted a question who does have a question still, our hospitals have been gracious enough to agree to answer the questions that have been submitted after the webcast. We have about 15 minutes left scheduled for the webcast, so if you enter your question within the next 15 minutes, then we should be able to provide those to the hospitals to answer, and they will be available on our website after they have been answered. And with that, I will turn it back over to Candace.

Candace Jackson: Thank you, Bethany. I would like to thank you for attending our webinar. We hope that you have learned some valuable information

from our speakers. As Bethany indicated, our WebEx will stay open until 3:30 Eastern Time for any questions that you want to send in. Again, all Questions and Answers will be answered and posted to QualityNet as well as our inpatient webpage at www.QualityReportingCenter.com. We thank you again, and enjoy the rest of your day.

END

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