Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Hospital Improvement Innovation Networks and Hospitals Collaboration to Improve Quality of Care: 30-Day Mortality Measures

Questions and Answers Transcript

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The following questions were asked, and responses given by subject-matter experts, during the live webinar. Questions and answers may have been edited for grammar.

Question 1: **What is HSR?**

Hospitals participating in the Hospital Inpatient Quality Reporting (IQR) Program receive annual Hospital-Specific Reports (HSRs) for the readmission, mortality, complication, payment, and Excess Days in Acute Care (EDAC) measures. The information in these HSRs can help hospitals interpret their performance on the measures before the information is publicly reported on *Hospital Compare*, understand which patients were included in their measure calculation, and identify areas for quality improvement effort. The Centers for Medicare & Medicaid Services (CMS) has released a new video to assist participants in the Hospital IQR Program with interpreting and understanding their HSRs. Watch the HSR video here: https://www.youtube.com/watch?v=0pE6VBUE8c8&t=17s.

Question 2: **On slide 29, Pinnacle 30-day mortality rate compared to the national mortality rate, are you using what CMS reports as your heart failure 30-day mortality rate or calculating on your own?**

This is Amy. For the time periods where we have the comparison data to the national mortality rate, that uses CMS reports. The data that are publicly reported on *Hospital Compare* for 2017 and 2018, because we do not have that national comparison yet for those time periods, are our own internal calculation.

Question 3: **On slide 18, can you give some examples of what is included in your heart failure passport and how it is used?**

We document in Epic and it is a way for the nursing staff to document the patient education that they complete. It is a way to document our tools that we give, our folder. We give the patients a calendar to record their weights, to document whether they have a scale, and to document their functional capacity for that particular day in the hospital. It is based on our stoplight—whether they are having a yellow day, a green day, a red day—and we compare that to their progressive mobility for that particular day or shift. It also uses a teach-back methodology so that the nursing staff can ask the patient specific questions and then document whether the patient had the correct answer and if the staff needed to reinforce that education.

Question 4: **What electronic health record (EHR) system do you use?**

We use Epic.

Question 5: **Regarding slide 20, how are the paramedic visits paid for?**

That is a service that is provided by our facility. There is not a charge to the patient. It is used as a means to supplement other community support that they have, not to replace home health nursing. That would be, you know, our first choice, but we have patients, of course, that refuse or the community paramedicine (CP) might be able to get in the first day after they go home, and then homecare starts the second day.

Question 6: **Slide 40. Dr. Kim, was your sepsis alert built into your EHR?**

Yes, the sepsis alert is built into the EHR so that the provider and nurses know that, when a patient flags as sepsis, that sepsis alert goes and we activate that.

Question 7: **On slides 29 and 30, I see you monitored the mortality rate for this population. Have you monitored your readmission rate? What shift have you seen in your readmissions as a result of your heart failure (HF) clinic program?**

This is Kim. I can answer that. We have, over the last six years, seen a steady decline in our all-cause heart failure readmission rates. Around 2013, we were right around 24 to 25 percent. We are currently at about 17 percent and ended Fiscal Year last year around 18 percent, but what we also see is a huge decline or a reduction in our readmission rates for patients that actually attend our outpatient heart failure center. Those rates have consistently been in the single digit for about the last five years.

Question 8: **Slide 20. Have you noticed reduced Medicare spending per beneficiary rates following some of your implementations of the practices mentioned? It seems like these activities would reduce costs associated with the 30-day readmission.**

Yes. We have seen our overall 30-day cost for heart failure patients drop, just as you mentioned, because of fewer readmissions. It is not something that we have really studied closely, but absolutely we are providing less costly care by keeping patients out of the hospital and out of the emergency room.

Question 9: **Slide 40. Dr. Kim, what electronic medical record (EMR) do you use?**

We use Epic.

Question 10: **Slide 40. Were you measuring time from door to start of IV antibiotics or to end time, and did you use average time or median time?**

We use start time to IV antibiotics. We use median time to look at all outliers, both on the good and the bad side.

Question 11: **Slide 18. Can you share what your stoplights are?**

It's really the tool on the slide. It is a very simple way to explain to the patients how they should monitor their symptoms. We start with the green zone and make sure that the patients can verbalize what they can do on their best day, which may not be ever that they are symptom free. Then, a yellow day is anything

that is different from their green day, the signs that are on the slide. Also, we strongly reinforce to people that, even on a green day there are particular activities they can complete, if it is harder to do or takes them longer to accomplish those activities, that makes it a yellow day. So, we try really hard to reinforce those subtle symptoms that are meaning that the patient's moving towards an exacerbation.

We've been very successful in incorporating this system wide. It is big win when. we saw not just nurses using this, you see it in the emergency room (ER) or in provider notes when they're out at their primary care physician (PCP).

It's been so successful that other care teams have adopted similar strategies. Our chronic obstructive pulmonary disease (COPD)team felt that it is something that they could use with that patient population and, recently, our diabetes team is looking at and developing something for their patients who come in with frequent readmissions for diabetic ketoacidosis (DKA) to help them better identify when they need to take action, especially with their sick-day guidelines.

The following questions were researched and answered by subject-matter experts after the live webinar.

Question 12: **Slide 11: Where did you obtain the state and national benchmarks?**

We obtained them from *Hospital Compare*.

Question 13: **Is there a way to get a copy of the patient education material?**

Yes, UPMC would be willing to share materials. Please send an email request to kfowler@pinnaclehealth.org (Kim Fowler).

Question 14: **Is the HF program the sole focus of the HF navigators, or are these staff nurses who do this on top of their other direct care duties?**

No, these are not staff nurses. They are distinct full-time employees (FTEs) with a separate job description. They support inpatient transition and have outpatient responsibilities and conduct nursing office visits.

What is the nurse/patient ratio for the HF navigators?

This ratio varies by acute care site. At one site, the Heart Failure Nurse Navigators (HFNNs) only see inpatients and the ratio averages 25:1. At the other two sites, the ratio is closer to 12:1 but, at these sites, the nurse may also have an outpatient visit in the afternoon.

Question 15: **I'm curious about the resources for the transition HF class.**

The HF resource nurse class is a blended learning course to build peer resources on the nursing units. The staff completes a mandatory computer-based learning (CBL) session and then attends a live class. The CBL is a review of basic pathophysiology and HF guidelines. The class builds on that general knowledge with advanced HF patient scenarios. The class portion is three hours. Continuing education hours are awarded.

Question 16: **How do you pursue ongoing education as residents graduate and new doctors/advance practice clinicians (APCs) join your organization?**

The HF program is part of resident orientation. Cardiology routinely participates in lunchtime conferences and education is provided as needed for action plans when metrics are not met. Orientation to the HF center by

the HF program manager is provided for all new cardiologists and most APCs with the cardiology practice. For our medical group, the physician responsible for quality has taken responsibility for education about the HF program. In addition, the HF program generally presents updates once a year at the medical group's quarterly meetings.

Question 17: **How does your program interface with community providers?**

The transition nurse contacts other providers in the community, such as dialysis, homecare, and rehab to be sure that the discharge plan is understood and that care, such as daily weights, is being done. The HF nurse navigators and certified registered nurse practitioners (CRNPs) send updates to all providers after outpatient visits.

Question 18: **Regarding slide 22, what "remote monitoring" do you have available?**

This is not done by the HF center. The nursing care coordinators in our medical group utilize telemonitoring. We are currently exploring a variety of HF apps for patient use. The HF center does conduct telemangement calls up to 30 days after discharge. These are just calls and do not utilize any other monitoring such as weight transmission.

Question 19: **Please explain how you can collect accurate data around 30-day HF mortality, especially through the continuum of care including patients that expire outside the Pinnacle Health System.**

We look to a variety of sources for data, including our own internal system, (which our billing department updates when it is notified of a death), our PCPs, specialty practices, and a national database of obituaries.

Question 20: **Regarding slide 24, what types of metrics are on your HF scorecard?**

The metrics on our HF scorecard are: 30-day all cause HF readmissions; readmissions with HF; adherence with 72-hour follow-ups; five-to-seven day follow-up appointments; evidence-based meds (beta blockers, ACE/ARB/ARNI, and aldactone); percent of palliative consults; HF mortality; ED utilization; and HF order set usage.

Question 21: **Are there professional guidelines that you referenced for your order sets?**

We follow *2013 American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Guideline for the Management of Heart Failure* or *2016 ACC/AHA/Heart Failure Society of America (HFSA) Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure* or *2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure*.

Question 22: **Did hospitalists resist ordering cardiology consults for inpatients?**

Occasionally they resisted, but it not a big issue.

Did primary care physicians resist referring patients to the HF clinic or to the cardiology clinic?

No. We even get referrals from other cardiology practices because there are two neighboring healthcare systems that do not have a nurse-run center such as our center.

Question 23: **Would UPMC be willing to share an example of the HF scorecard?**

Please see the example located here: https://www.qualityreportingcenter.com/wp-content/uploads/2018/05/HF-Scorecard.xlsx

Question 24: **Regarding slide 26, do you use an inpatient or outpatient hospice?**

We use both.

Question 25: **Is it a Health Insurance Portability and Accountability Act (HIPAA) issue if outside palliative care nurses sit in on patient huddles?**

No, we have business agreements in place with each agency.

Question 26: **Have the readmissions for HF decreased at a similar rate?**

Yes, readmissions initially decreased at a similar rate. Over the last two years, we have held a consistent readmission rate and met our system goals.

Question 27: **On slide 29, does 2018 mean since January?**

No, 2018 is referring to data that started in July 2017.

Question 28: **Regarding slides 25 and 26, does hospice care need to be documented on Day 1 of stay?**

For the patient to be excluded from the 30-day mortality measure, hospice must be started on Day 1. For us, the benefit of having hospice services allows us to discharge the patient to home with hospice. Many patients

survive more than 30 days with hospice care, some months and even a year or longer.

Question 29: **Are the inpatient mortality results specific to heart failure mortality or all conditions?**

The inpatient mortality results are specific to only heart failure mortality.

Question 30: **Do you exclude palliative or hospice patients from your inpatient mortality data?**

No, we follow the CMS definition, which only excludes the patient from the measure if hospice is started on Day 1, which is not often.

Question 31: **What is the top barrier to improving patient compliance with using the congestive heart failure (CHF) stoplight system?**

There really are no barriers. The method is accepted by patients and providers. In patient focus groups, they have stated that it is easy to use. We also have a low-literacy version and it is translated into a few other languages.

Question 32: **Who makes the follow-up appointment before the HF patient leaves?**

It is a shared responsibility of the HF navigator and the outcomes management department.

What process do you have?

The outcomes management department has a “resource center.” Upon an electronic request to make an appointment, they call PCP offices and make

the appointments. The appointment requests are prioritized based on projected discharge dates. The HF navigators make appointments that are to occur within the HF center with our CRNPs.

Question 33: **To Kim Fowler: The initiatives and outcomes presented demonstrate a very successful program.**

Thank you for your kind comment.

How have the outcomes been affected since transitioning to a larger health system and what challenges/barriers have you had to overcome regarding the program?

At this point, my work continues to be with our legacy acute care hospitals and one of the newly-acquired hospitals that is only about 20 miles from our legacy hospitals. I have hired a HF navigator for that site.

Question 34: **What is your sepsis bundle performance percent over the past several months?**

It was 72 percent overall in the last three months and, in FY 2017, it was 64 percent.

Question 35: **What does OFI stand for?**

Opportunities for Improvement.

Question 36: **How can we get in touch with Brian Kim from Henry Ford Allegiance Health?**

His cell number is (248) 255-5014. His office number is (517) 205-7244.

Question 37: **This question is for Dr. Kim: Has your specific sepsis unit seen a drop in the sepsis mortality numbers as well?**

We initiated in December and are seeing positive results.

Question 38: **Are the positive results being compared within the sepsis unit alone or hospital-wide?**

The positive results are compared hospital-wide.

Question 39: **What are your recommendations for an emergency department (ED) that is pushing back on doing sepsis screens on patients greater than 18 at triage?**

For those greater than 18, it is part of the normal flow process. Early recognition is important and prudent. I am unclear why they would not want to utilize a sepsis screening tool. My number is listed. Feel free to call me at (248) 255-5014.

Question 40: **For the sepsis presenter hospital, do they use a sepsis advisor embedded in their EHR?**

We use BPA. We use a sepsis screening tool every 12 hours.

Question 41: **Is Henry Ford Allegiance Health part of a corporate system of hospitals? If so, did they consider implementing some processes across their entire system and what would that entail?**

We are part of the Henry Ford Health System and, yes, we are working to standardizing the sepsis process throughout all the units in the system.

Question 42: **How did you get buy-in for the dedicated sepsis unit? Did the staff receive additional education?**

We looked at the data and utilized our success with dedicated units such as heart, stroke, and trauma. We also looked at the idea of improving readmissions, length of stay (LOS), and mortality. The staff received instruction before and education continues on a regular basis.

Question 43: **Regarding slide 44, can you give us an overview of your sepsis unit? Who manages the unit, an MD, RN, or someone else?**

This is a 19-bed acuity adaptable unit. Patients in septic shock do not come to this unit, but all others do. Nurse managers run the unit. We utilize our hospitalist for progressive rounding in the unit**.**

Question 44: **Can you tell us again what sepsis process measures you were monitoring as part of your initiative (e.g., lactate draw)?**

We monitored all the measures in the CMS sepsis bundle.

Question 45: **Are you using brain natriuretic peptide (BNP) as a differential for diagnosis of CHF?**

BNP is on our HF order set and we also work to follow the most recent update (2017) to the 2013 HF guidelines in which use of biomarkers is addressed. During daily surveillance, the HF nurse navigators use a >400 BNP report to screen potential HF patients that were not identified in another manner.

Question 46: **Please share what your sepsis bundle compliance rate is?**

Our sepsis bundle compliance rate is 64 percent year to date.

Question 47: **For sepsis, we have heart failure patients that fall out due to the 30ml/kg requirement. Any suggestions?**

That is a tough question because we fall out on this measure with patients that have CHF and are in heart failure. I have asked my colleagues to utilize bedside ultrasound and document inferior vena cava (IVC) measurements which will indicate if the patient fluid overloaded. This allows the clinician at bedside to see if the patient will be responsive to the fluid bolus.

Question 48: **Where is the HF care plan documented so all providers, including CP, can see it?**

The plan is within Epic and our HF transitional nurse routinely speaks with the CP team to share the plan of care or care concerns. We are currently working with the Epic team to finalize a FYI flag with discharge concerns and plans.

Question 49: **Are sepsis patients identified for the sepsis unit by a four-lactate draw? Is that their initial lactate or all lactates during their sepsis admission?**

It is all lactates during their sepsis admission.

Question 50: **General question regarding HF: How are you able to sustain the 30-day and 7-day follow-up for population?**

The HF navigators are the key to making sure that patients are discharged with a 7-day follow-up, either with the CNRPs in our center or with their PCP. Our fall-outs are due to patient refusal or PCP refusal to make an appointment without the patient calling first (due to frequent no-show

history). Our ongoing follow-up is good and dependent on patient willingness to come to the center or accept telemangement calls.

Question 51: **For UPMC: Since you use Epic, have you been able to add a medicine indication for every discharge medication to meet The Joint Commission Advanced Certification Heart Failure (ACHF)-03 requirements?**

No, we continue to struggle with this metric.

Question 52: **Is the sepsis alert automated or humanly driven?**

The sepsis alert is automated.

Question 53: **Dr. Kim, Has Henry Ford Allegiance Health explored the new Epic sepsis predictive analytical tool? If so, is there a reason why you are not using it?**

No. **Henry Ford Allegiance Health** has not explored it, not that I know of.

Question 54: **With the sepsis automated alert, what EHR do you use? Is this automated alert provided by your EHR vendor or someone else?**

We use Epic to provide the automated alert.

Question 55: **On slide 21, can you describe in more detail what virtual HF visits look like?**

We identified that distance and cost of travel (gas and time for caregivers) are barriers to patients attending our outpatient HF center for HF navigator visits. Patients present to a cardiology unit which is about 40 miles from our office. The medical assistants check them in (weight, vital signs, etc.)

and then the HF navigator remotes in via a computer robot. In essence, we Skype with the patients with some extra features. The robot has technology to allow for auscultation and zoom-in viewing of patient. If you are a nurse, please attend the American Association of Heart Failure Nurses (AAHFN) conference in Chicago to hear more about our program at one of the power hours.

Question 56: **Are the physicians at Pinnacle employed by Pinnacle or are they independent?**

Both. Our cardiology and hospitalist groups are employed. We have private internal medicine groups that still admit patients to the hospitals.

Question 57: **Regarding slide 40, do you have an automatic lactate order triggered from the alert?**

Yes.

Question 58: **Regarding slide 29, UPMC mentioned the use of *Hospital Compare* data in conjunction with internal data to present heart failure mortality rates. How do you make your internal data definition comparable to the *Hospital Compare* data definition?**

We use the same specifications, but we cannot risk-adjust the rate. So, we are tracking an actual rate per 100 admissions while CMS severity adjusts the rate.

Question 59: **What were the main causes of mortality for sepsis based on your root cause analysis (RCA?)**

It is pneumonia.

Question 60: **May I ask what your SEPSIS results are for January 2018? Are they better than the national statistics?**

They are 10 percent for severe mortality rate, 29 percent for septic shock mortality, and overall 19 percent. I believe they are better than the national statistics, but the new results are coming out next month

Question 61: **Slide 40: What are the former and current antibiotic measures? Is the metric from door to antibiotic start time or from diagnosis to antibiotic start time?**

It is from diagnosis to antibiotic, which is very similar to door to antibiotic because of our triage process.

Question 62: **On slide 18, I see your HF center number on the form. Do you take calls from patients that decline follow-up in the clinic?**

Yes. Often patients change their mind and then we get them set-up in the center. We can also help patients navigate and get an appointment in their PCP office, or we are glad to answer non-medical questions related to self-care. Again, we encourage patients with questions to get ongoing support, if not with us then with their PCP.

Question 63: **Regarding Code Sepsis on slide 40, our physicians are having difficulties ordering target ordered volume to be 30ml/kg and document rate and time. Is this part of the EHR order set with Epic?**

Yes.

Question 64: **Does your team abstract sepsis concurrently or post-discharge only?**

We abstract concurrently for some cases, but post-discharge is handled by a third-party vendor.

Question 65: **What type of screening is happening in triage?**

Nurses use a sepsis screening tool that alerts them to potential septic patients and initiates the orders to start the workup.

Question 66: **Regarding slide 40, what were your sepsis bundle compliance rates for 2017?**

They were 64 percent.