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Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor (SC)

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

March 13, 2018
Speakers

- **Wendy Boersma**, DNP, RN, NEA-BC, Vice President and Chief Nursing Officer, Henry Ford Allegiance Health
- **Brittany Bogan**, MHSA, CPPS, Vice President, Patient Safety & Quality, Michigan Health & Hospital Association Keystone Center, Great Lakes Partners for Patients Hospital Improvement Innovation Network (HIIN)
- **Kim Fowler**, MSN, RN, CNS-BC, CHFN, Heart Failure Manager, UPMC Pinnacle
- **Amy Helmuth**, MS, RN, FACHE, System Vice President, Organizational Quality/Chief Quality Officer, UPMC Pinnacle
- **Brian Kim**, MD, Emergency Department Chairman, Chief of Staff-elect, Henry Ford Allegiance Health
- **Robert G. Shipp III**, MSHSA, RN, NEA-BC, Vice President, Population Health Strategies, The Hospital and Healthsystem Association of Pennsylvania

**Moderator**

**Maria Gugliuzza**, MBA, Project Manager
Hospital Value-Based Purchasing (VBP) Program
Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)
Purpose

This event will provide an overview of hospital and HIIN initiatives and activities that sustain and accelerate progress and momentum toward better patient outcomes. Hospitals and HIINs will share their solutions and processes to reduce 30-day heart failure and sepsis mortality rates.
Objectives

Participants will be able to:

• Apply initiatives and activities to improve patient outcomes.

• Identify tools to achieve quality measurement goals.

• Recall the systems and protocols implemented by hospitals to monitor progress for 30-day mortality measures.
Improving Heart Failure Mortality
UPMC Pinnacle

• Before June 2017:
  o 3-hospital PinnacleHealth System
  o In central Pennsylvania
  o 509 beds

• As of September 2017:
  o 8-hospital system UPMC Pinnacle
  o 1,267 beds
UPMC Pinnacle Heart Failure Program

• Despite success with process of care measures, outcomes were not meeting goals.
• Heart failure (HF) inpatient mortality rate and mortality rate within 30 days exceeded state and national benchmarks.
Interdisciplinary Collaborative Team Approach

Provide comprehensive HF care:

A continuum of specialized medical care in combination with education and lifestyle modification to promote and to assist patients with achieving maximum independence in their care, and transitioning patients from the hospital to home environments.
Meet Our Interdisciplinary Team

- **Heart Failure Program**
  - Clinical nurse specialist/manager
  - Nurse navigators
  - CRNPs
  - Transitional RN
- **Nurses**
  - Inpatient and community
  - Educators and CNSs
  - Managers
- **Providers**
  - HF medical director
  - Cardiologists
  - Hospitalists – 2 HF specialists
  - Palliative medicine
  - Medical group
  - Post-acute care network

- **Dietitians**
- **Cardiac rehab**
- **Outcomes management**
- **Care management team**
- **Clinical pharmacist**
- **Occupational therapy**
- **Community paramedicine**
- **Quality improvement**
- **Performance improvement**
Scope of Services

• Care across the continuum
  o Inpatient coordination by interdisciplinary team
  o Transitional care
  o Collaboration with other care facilities, primary care physicians (PCPs), cardiologists, and agencies that provide social and medical needs

• Community outreach
• Performance improvement initiatives
• Professional development and dissemination of best practice
HF Care Across the Continuum

- Acute care
- Transition plan
- Early post-discharge follow-up
- PCP and other community services
- Ongoing care in HF Center
Standardized Evidence Based Care

• 2013 ACCF/AHA Guideline for the Management of Heart Failure
  o 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure

• Heart Failure Society of America (HFSA)

ACC = American College of Cardiology
ACCF = American College of Cardiology Foundation
AHA = American Heart Association
Inpatient Care

• Order Sets
  o Heart failure inpatient
  o Peripheral IV diuretic orders
• Protocols
  o Heart failure program
• Best practice alerts
  o New York Heart Association (NYHA)
• Hospitalist HF specialists
Inpatient Care

- Daily surveillance by Heart Failure Nurse Navigators (HFNN)
  - BNP report
  - Unit-based huddles
  - Interdisciplinary rounds
- Consistent approach to symptom management
  - Stoplight
  - Calendar and HF binder
  - Individualized care plan using HF passport
Strong Transition Plan

- 72-hour evaluation
- Post-hospital appointment
- Optimize evidence-based care
- Heart Failure Center (HFC) coordination
- Engage all team members
Immediate Post-hospital Care
Heart Failure Center

• Follow-up call from HF nurse completed within 72 hours.
• Transition of care appointment scheduled within 7 days.
• Transitional HF nurse communicates with other agencies and keeps patients linked to our services.
  o Community Health Nurse
  o Paramedicine
  o Post-acute care network
  o Home care and hospice
Heart Failure Clinic

- 2 clinics staffed by CRNP, HFNN
- Virtual HF visits
- More than 600 patients annually
Focus: Offer Evidence-Based Care and Reduce Barriers to Care

- Team education
- HF scorecard
- Integration of palliative care
- HF hospitalist service to improve consistency of care
- Optimization of guideline-directed medical therapy (GDMT) and advanced HF care (home inotropic therapy)
- Use of HF clinic and observation unit to manage symptoms
- Increase use of remote monitoring
- Literacy and cultural diversity
Team Education

• Development of a heart failure resource nurse program to increase peer leaders
• Computer-based learning regarding standard heart failure patient education and evidence-based care
• Shadowing experiences in Heart Failure Center for RNs
• Nurse residency program presentations
• Cardiology education to residents and peer-to-peer hospitalist education
• Bi-weekly heart failure classes and 3 large patient-centered events annually
Heart Failure Scorecard

Transparency of data

- HF committee
- Hospitalist, cardiologist, teaching service
- Quality committees
- Provider practices
- Nursing and other allied health professionals
- Board of Directors
Supportive Care and Palliative Medicine

Root cause analysis (RCA) of all mortalities identified need supportive care and palliative medicine.

- Palliative Consult orders on HF order set:
  - Palliative Care for **Stage C Heart Failure**
    - For chronic disease management; determine goals for therapy
  - Palliative Care for **Stage D Heart Failure**
    - For hospice, end of life plan of care

- Learning system
- No "department"
- Overwhelmed by inpatient work

- Hire of new outpatient CRNP

- Outpatient visits in HFC
- Team meetings with HFC and Cardiology
- How to support earlier conversations
- Challenge to staff on Palliative end

- New providers
- Supportive care Nurse Navigators
- **THIS TIME IT WILL WORK!!!**

Under Oncology Service line
Imbedding Hospice Project

Nov & Dec 2016
• Initial meetings – difficulty getting patients into hospice; concern for higher than expected inpatient mortality, tickets open for EPIC – lack of transparency for advance directives in EMR

Early 2017
• Interdisciplinary team to discuss EPIC concerns, culture of system regarding hospice/palliative care; team accountability; team education at all levels

April 2017
• National Decision Making Day Activities
• Team education
• Improve EPIC documentation – Advanced directives tab/banner changes

Summer 2017
• Continued case reviews of HF mortality
• Start of imbedded Hospice agencies – June, 2017

Key patient outcomes: transparent goals of care in EMR, ongoing goals of care discussion across continuum, easy transition into hospice
YOU ARE INVITED:

Annual – Heart Failure Garden Event

Tuesday, June 20th
10:00 – 11:00

Heart Failure Center, Bloom Building
2nd Floor, 4310 Londonderry Road
Harrisburg, PA
RSVP – 717-920-4201

Come to this FREE event to sample summer recipes featuring our vegetables and herbs.
Low Sodium Food Pantry

Many generous donations from the following:

- Fellow UPMC Pinnacle co-workers
- Giant Foods
Results: 30-Day Mortality Rate

Heart Failure 30 Day Mortality Rate

- 2011-2014: Pinnacle 13.50% vs National 11.60%
- 2012-2015: Pinnacle 12.10% vs National 12.70%
- 2013-2016: Pinnacle 11.50% vs National 11.90%
- 2017: Pinnacle 12.60%
- 2018: Pinnacle 8.90%
Results: Inpatient Mortality

- Baseline: 6.2%
- Jan-Dec 2013: 4.0%
- Jan-Dec 2014: 2.4%
- Jan-Dec 2015: 2.3%
- Jan-Dec 2016: 2.7%
- Jan-Oct 2017: 1.9%
- Target: 1.3%
Brittany Bogan, MHSA, CPPS, Vice President, Patient Safety & Quality, Michigan Health & Hospital Association Keystone Center, Great Lakes Partners for Patients HIIN

Wendy Boersma, DNP, RN, NEA-BC, Vice President and Chief Nursing Officer, Henry Ford Allegiance Health

Brian Kim, MD, Emergency Department Chairman, Chief of Staff-elect, Henry Ford Allegiance Health

Henry Ford Allegiance Health Overview
Hospital Improvement Innovation Network

- CMS HIIN contract awarded to the Michigan Health & Hospital Association Foundation on September 28, 2016.
  - Two-year contract with an optional third year based on performance
- Michigan, Illinois and Wisconsin hospitals are in partnership with respective state hospital associations (318 hospitals in total) – Great Lakes Partners for Patients HIIN.
- Hospital enrollment began in November 2016.
- Model for improvement will use data to identify hospitals with opportunities for improvement and then provide direct support and Improvement Action Networks.
HIIN Scope of Work

- Adverse drug events
  (opioid safety, anticoagulation safety, glycemic management)
- Catheter-associated urinary tract infection (CAUTI)
- Central line-associated bloodstream infection (CLABSI)
- *Clostridium difficile* infection
- Injury from falls and immobility
- Pressure ulcers
- Sepsis and septic shock
- Surgical site infection (SSI)
- Venous Thromboembolism
- Ventilator-associated events (VAE)
- Readmissions
- Delirium prevention in the ICU
- Methicillin-resistant *Staphylococcus aureus* (MRSA) infection
Henry Ford Allegiance Health (HFAH) is a 475-bed health system in Jackson, Michigan. HFAH complements traditional acute care services with primary and community-based care to support patients across the health continuum at every stage of life.
• Jackson County population: 160,000
• Payor mix
  o 35% Medicare
  o 15% Medicaid
  o 25% Blue Cross
• 475 beds
• 3,887 staff
• 259 physicians
  o 131 employed
  o 128 independent
HFAH Services Overview

- Acute care hospital
- Long-term acute care hospital
- Emergency care
- Level II trauma center
- Cancer center/hematology-oncology
- Cardiac universal bed unit
- Residential hospice home
- Neurology and neurosurgery
- Cardiology
- Vascular
- Oncology
- Orthopedics
- Dermatology/plastic surgery
- Obstetrics/gynecology
- 40 clinical locations, including primary and specialty care, diagnostics and outpatient surgery
Brittany Bogan, MHSA, CPPS, Vice President, Patient Safety & Quality, Michigan Health & Hospital Association Keystone Center, Great Lakes Partners for Patients HIIN

Wendy Boersma, DNP, RN, NEA-BC, Vice President and Chief Nursing Officer, Henry Ford Allegiance Health

Brian Kim, MD, Emergency Department Chairman, Chief of Staff-elect, Henry Ford Allegiance Health

Successes with Sepsis Bundle
Sepsis Committee Role

- Interdisciplinary
- Define and coordinate sepsis care
- Define and revise protocols for sepsis care hospital-wide
  - Initial focus was in the emergency department (ED) and critical care (CC)
  - Enhancement to tools to support sepsis management
  - Patient placement guidelines and throughput
  - Education to the clinical team
- Review Core Measure abstraction data
  - High attention to opportunities for improvement (OFIs)
Engagement of the Clinical Care Team

• Cannot highlight this enough
• Multidisciplinary team and provider engagement a must
• Empowering registered nurses to activate sepsis care
What is Working

• Defined physician and nursing champions
  o ED, CC, infectious disease, sepsis coordinator
  o Dedicated sepsis coordinator
    ▪ Data/case review, coordinate meetings and education

• Sepsis alerts and Code Sepsis

• Tools and order sets guiding care that decreases variability

• Sepsis bundle compliance
Severe Sepsis

Severe Sepsis Mortality (excludes Septic Shock)

Mortality Rate

0% 5% 10% 15% 20% 25% 30% 35% 40%

Month


CL 0.0896
UCL 0.2862

3/13/2018
Septic Shock Mortality

Septic Shock Mortality

Mortality Rate

Month

UCL 0.5542

CL 0.2660

3/13/2018
Dedicated Sepsis Unit:
Transforming our Approach to Sepsis Management
Sepsis Unit

- 19-bed medical/surgical unit
- Lactic acid level <4
- Primary diagnosis of sepsis and actively treating
Lessons Learned

• Decrease variability in the way sepsis is managed
• Continuous team engagement
• Celebrate successes
• Study OFIs
• Using a methodology such as Plan-Do-Study-Act (PDSA)
Hospital Improvement Innovation Networks and Hospitals Collaboration to Improve Quality of Care: 30-Day Mortality Measures

Questions/Discussion
Continuing Education Approval

This program has been pre-approved for 1.0 continuing education (CE) units for the following professional boards:

• **National**
  o Board of Registered Nursing (Provider #16578)

• **Florida**
  o Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  o Board of Nursing Home Administrators
  o Board of Dietetics and Nutrition Practice Council
  o Board of Pharmacy

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12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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Last Name: 
Email: 
Phone: 
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CE Credit Process: Existing User
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