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Nebraska and NHA Quality Initiatives

Session 2

nebraskahospitals.org

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Learning Objectives

- Describe Nebraska quality initiatives
- Explain NHA’s role in statewide healthcare quality

NHA Quality Team:

- Margaret Woeppel MSN, RN CPHQ | Vice President, Quality & Data & Workforce
  - mwoeppel@nebraskahospitals.org
- Dana Steiner BSN, MBA, CPHQ | Senior Director, Quality & Performance Improvement
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- Amber Kavan RN, BSN, CPHQ | Director Quality & Performance Improvement
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- Matt Lentz RN, MSN | Quality & Performance Improvement Consultant
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- Sachi Verma| Director of Health Data
  - sverma@nebraskahospitals.org
- HQIC Advisory Council

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Nebraska HQIC Strong

- Annie Jeffrey Memorial County Health Center
- Antelope Memorial Hospital
- Avera Creighton Hospital
- Avera St. Anthony's Hospital
- Beatrice Community Hospital & Hlth Ctr
- Boone County Health Center
- Box Butte General Hospital
- Brodstone Memorial Hospital
- Brown County Hospital
- Butler County Health Care Center
- Callaway District Hospital
- Chadron Community Hospital
- Chase County Community Hospital
- Cherry County Hospital
- CHI Health Plainview
- CHI Health Schuyler
- CHI Health St Mary's
- Columbus Community Hospital
- Community Hospital
- Community Hospital Association-Fairfax
- Community Medical Center
- Cozad Community Health System
- Crete Area Medical Center
- Dundy County Hospital
- Faith Regional Health Services
- Fillmore County Hospital
- Franklin County Memorial Hospital
- Genoa Community Hospital
- Gordon Memorial Hospital District
- Gothenburg Health
- Grand Island Regional Medical Center
- Great Plains Health
- Harlan County Health System
- Henderson Health Care
- Howard County Medical Center
- Jefferson Community Health & Life
- Jennie Melham Memorial Medical Center
- Johnson County Hospital
- Kearney County Health Services
- Kearney Regional Medical Ctr
- Kimball Health Services
- Lexington Regional Health Center
- Mary Lanning Healthcare
- Memorial Community Hospital & Health System
- Memorial Health Care Systems
- Memorial Hospital
- Merrick Medical Center
- Methodist Fremont Health
- Morrill County Community Hospital
- Nebraska Spine Hospital
- Nemaha County Hospital
- Niobrara Valley Hospital
- Osmond General Hospital
- Pawnee County Memorial Hospital
- Pender Community Hospital
- Perkins County Health Services
- Phelps Memorial Health Center
- Providence Medical Center
- Regional West Garden County
- Rock County Hospital
- Saunders Medical Center
- Sidney Regional Medical Center
- St Francis Memorial Hosp (Franciscan Healthcare)
- Syracuse Area Health
- Thayer County Health Services
- Tri Valley Health System (Cambridge Memorial Hospital)
- Twelve Clans Unity Hospital
- Valley County Health System
- Warren Memorial Hospital (Friend Community Healthcare System)
- Webster County Community Hospital
- West Holt Memorial Hospital
- York General Hospital

72 STRONG

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Telligen HQIC Team:

Name	Email
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Other Telligen Partners:

- ✓ Alaska State Hospital & Nursing Home Association
- ✓ Idaho Hospital Association
- ✓ Oklahoma Hospital Association
- ✓ Wyoming Hospital Association
- ✓ Mountain-Pacific Quality Health

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HQIC Overview

Target Population for the HQIC Grant:

- Rural Hospitals
- Critical Access Hospitals
- Hospitals serving:
  - Populations with poor access to alternative hospital settings
  - Vulnerable populations: elderly, medically underserved, chronically ill, low-income and/or homeless

HQIC Increase Patient Safety– Decrease Patient Harm

- Opioid Stewardship
- Adverse Drug Events
- Central Line-associated Blood Stream Infections
- Catheter-associated Urinary Tract Infections
- C-diff, MRSA and Antibiotic Stewardship
- Sepsis and Septic Shock
- Pressure Ulcers
- Readmissions

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HQIC Goals:

3 Main Goals

1. Improve Behavioral Health Outcomes and Decrease Opioid Misuse
2. Increase Patient Safety
3. Improve Quality of Care Transitions

Supportive Goals

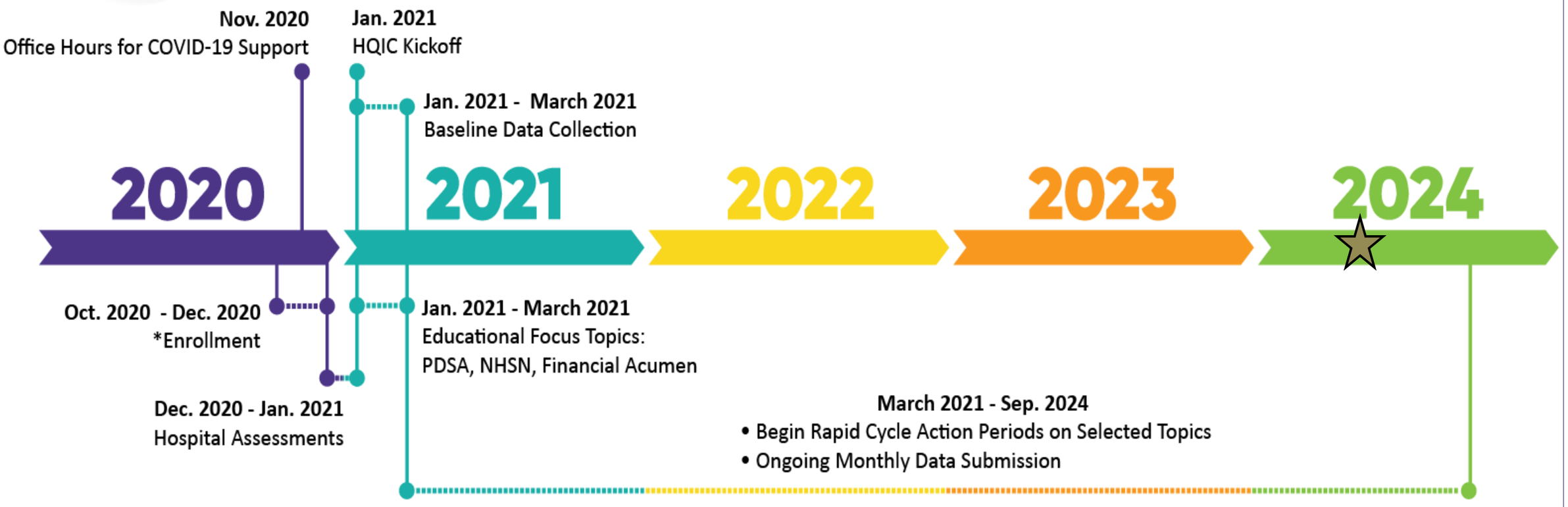
1. Support Hospitals in response to public health emergencies
2. Facilitate authentic person and family engagement
3. Address Disparities
4. Engage Hospital Leadership
5. Promote Antibiotic Stewardship

Facilitate authentic person and family engagement

1. Implementation of a planning checklist for patients known to have a planned admission
2. Implementation of a discharge planning checklist
3. Conducting shift change huddles and bedside reporting with patients and families
4. Designation of an accountable leader in the hospital who is responsible for person and family engagement
5. Hospitals to have an active Person & Family Engagement Committee where patients are represented and report to the Board


Increase Patient Safety
Support Local Communities
Support Vulnerable Populations and Reduce Healthcare Disparities
Improve Behavioral Health Outcomes and Decrease Opioid Misuse
Increase Person and Family Engagement
Increase Quality of Care Transitions
3 Goals and 3 Cross-Cutting Focus Areas

HQIC Timeline



*Additional enrollment through March 2021

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HQIC Measures

Improve Behavioral Health Outcomes & Decrease Opioid Misuse

- Decrease opioid related adverse events, including deaths, by 7% with a focus on Medicare beneficiaries using opioids.
  - Decrease opioid related adverse events by 7%, including deaths with a focus on the Medicare population
  - Decrease opioid prescribing (for prescriptions ≥ 90 MME daily) across recruited, acute care hospitals by 12%.

Improve Quality Of Care Transitions

- Reduce hospital readmissions by 5% in recruited hospitals.

Improve Patient Safety

- Reduce all-cause harm in hospitals by 2024, including: reduce by 9% or more all-cause harm in recruited hospitals to include reducing Adverse Drug Events (ADEs).

Reduce all-cause harm in hospitals by 9% or more by 2024.
Reduce readmissions by 5% for the recruited population by 2024.
Reduce ADEs in hospitals by 13%.

Reduce Clostridioides difficile (C. difficile, formerly known as Clostridium difficile) in hospitals.

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HQIC Data Collection Processes

- **Hybrid Data Collection for HQIC:**
  - Medicare Fee-for-Service Claims
  - Infection Prevention Measures:
    - NHSN
    - Self-reported
  - Self-Reported Nebraska Measures

- Use CDS Data Repository – AHA Comprehensive Data System (ahacds.org)

Measure (click the i button for measure specifications)		Monitoring Period	Baseline Status	Monitoring Status	
Opioid Related ADEs (self-reported): Tell_SR_NEOP Outcome (Recommended)		1/1/2021 - 12/31/2024 (Monthly)	Most recent data: 10/01/2020	Most recent data: 12/01/2022	Enter Data
Glycemic Management ADEs (self-reported): Tell_SR_NEGL Outcome (Recommended)		1/1/2021 - 12/31/2024 (Monthly)	Most recent data: 10/01/2020	Most recent data: 12/01/2022	Enter Data
Catheter Utilization Ratio all units (Self Reported): Tell_SR_CAU3 Outcome (Recommended)		9/1/2020 - 9/30/2024 (Monthly)	Most recent data: 08/01/2020	No Data	Enter Data
CAUTI Rate all units (Self Reported): Tell_SR_CAU2 Outcome (Recommended)		9/1/2020 - 9/30/2024 (Monthly)	Most recent data: 08/01/2020	No Data	Enter Data
CDI Rate (Self Reported): Tell_SR_CDI2 Outcome (Recommended)		1/1/2021 - 9/30/2024 (Monthly)	Most recent data: 12/01/2020	No Data	Enter Data
MRSA Rate (Self Reported): Tell_SR_MRSA2 Outcome (Recommended)		9/1/2020 - 9/30/2024 (Monthly)	Most recent data: 08/01/2020	No Data	Enter Data
Falls Rate: Tell_SR_NEFALL Outcome (Recommended)		1/1/2021 - 12/31/2024 (Monthly)	Most recent data: 07/01/2020	Most recent data: 12/01/2022	Enter Data
Assisted Fall Rate: Tell_SR_NEAFR Outcome (Recommended)		1/1/2023 - 12/31/2024 (Monthly)	No Data	No Data	Enter Data
Unassisted Fall Rate: Tell_SR_NEUFR Outcome (Recommended)		1/1/2023 - 12/31/2024 (Monthly)	No Data	No Data	Enter Data
All Cause Readmission Rate : Tell_SR_NERead Outcome (Recommended)		1/1/2021 - 12/31/2024 (Monthly)	Most recent data: 10/01/2020	Most recent data: 01/01/2023	Enter Data

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HQIC Measure List

Medicare FFS Claims	Infection Prevention	Self-Reported
Opioid Prescribing Practices (Claims): Tell_Core_OP1	Central Line Utilization Ratio - All Units (NHSN): Tell_Core_CLAB3 / / (Self Reported): Tell_SR_CLAB3	Opioid Related ADEs (self-reported): Tell_SR_NEOP
Opioid Related ADEs (Claims): Tell_Core_ADE1c	CLABSI Rate all units (NHSN): Tell_Core_CLAB2 / / (Self Reported): Tell_SR_CLAB2	Glycemic Management ADEs (self-reported): Tell_SR_NEGL
Glycemic Related ADEs (Claims): Tell_Core_ADE1b	Catheter Utilization Ratio all units (NHSN): Tell_Core_CAU3 / (Self Reported): Tell_SR_CAU3	All Cause Readmission Rate : Tell_SR_NERead
Anticoagulation Related ADEs (Claims): Tell_Core_ADE1a	CAUTI Rate all units (NHSN): Tell_Core_CAU2 / (Self Reported): Tell_SR_CAU2	Falls Rate: Tell_SR_NEFALL
ADE Rate (Claims): Tell_Core_ADE1	CDI Rate (NHSN): Tell_Core_CDI2 / (Self Reported): Tell_SR_CDI2	Assisted Fall Rate: Tell_SR_NEAFR
Postoperative Sepsis Rate (Claims): Tell_Core_Sep1	MRSA Rate (NHSN): Tell_Core_MRSA2 / (Self Reported): Tell_SR_MRSA2	Unassisted Fall Rate: Tell_SR_NEUFR
Sepsis Mortality Rate: Tell_Core_Sep2	SSI Rate Colon Surgeries (NHSN): Tell_Core_COLO2 / (Self Reported): Tell_SR_COLO2	
Pressure Ulcer Rate, Stage 3+ (Claims): Tell_Core_PRU1	SSI Rate Total Knee Replacements (NHSN): Tell_Core_HPRO2 / (Self Reported): Tell_SR_KPRO2	
Hospital-acquired Pressure Ulcer Prevalence, Stage 2+ (Claims): Tell_Core_PRU2	SSI Rate Total Hip Replacements (NHSN): Tell_Core_KPRO2(Self Reported): Tell_SR_HPRO2	
All Cause Readmission Rate (Claims): Tell_Core_Read1		
Unplanned All-Cause 30-Day Readmission Rate: Tell_Core_Read2		
Falls - CMS HAC (Claims): Tell_Core_Fall1		
PE/DVT Rate (Claims): Tell_Core_DVT1		

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HQIC Measure List

- Telligen Portal: Communication and Information Hub
  - ✓ QIN-QIO Portal (telligenqinqio.com)
- Comprehensive Data System (CDS): Data Repository
  - ✓ AHA Comprehensive Data System (ahacds.org)
- Nebraska Hospital Association Website:
  - ✓ NHA Home page (nebraskahospitals.org)
  - ✓ Currently being updated
- CDC – NHSN
  - ✓ https://www.cdc.gov/nhsn/index.html
- Institute for Healthcare Improvement
  - ✓ http://www.ihi.org

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HQIC Process Improvement

Key Elements:

- IHI Model for Improvement
- PDSA Cycles – Rapid Cycle Improvement

HQIC Consult Visit:

- Project specific education / audits / infrastructure creation

Interim Quality Contracting

- Offer onsite quality subcontracting to address staffing shortages, vacation, medical leave, or project oversight

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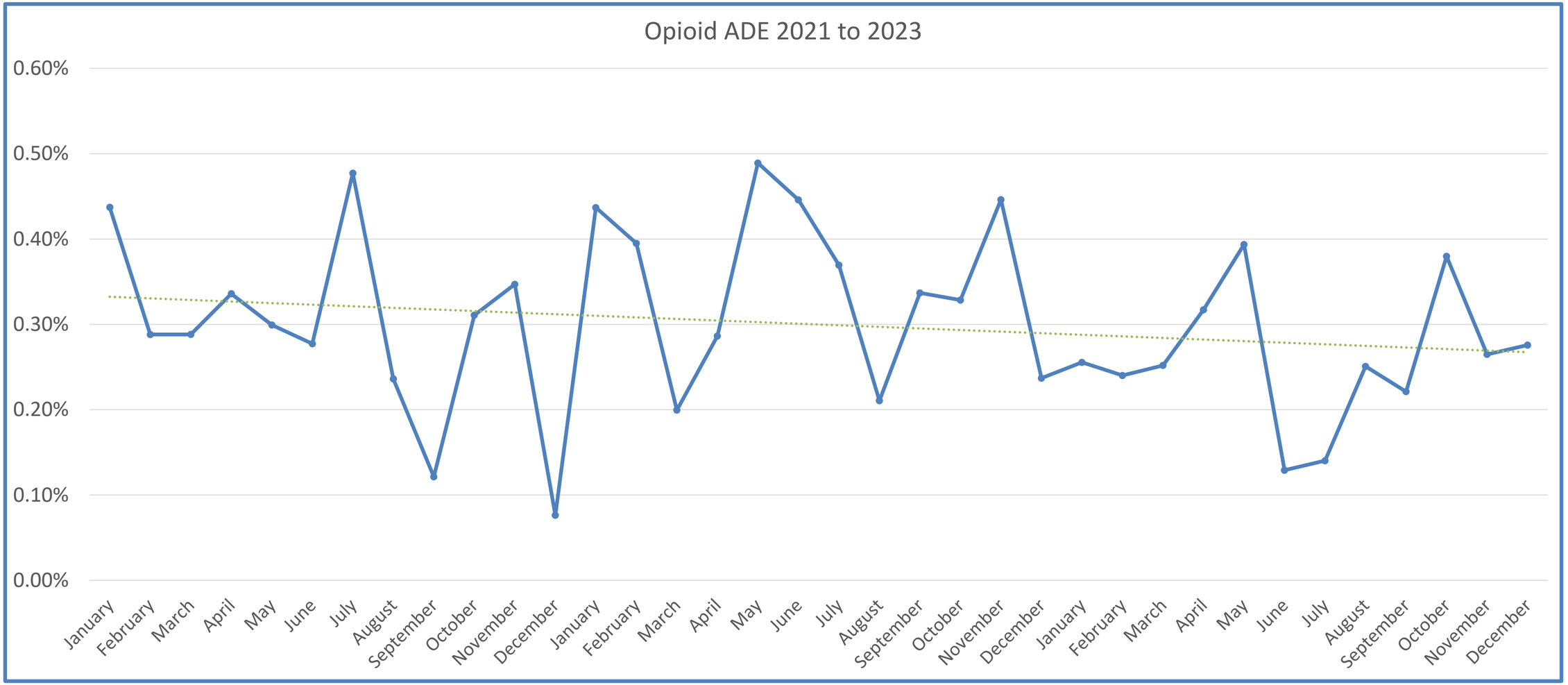
Data Review



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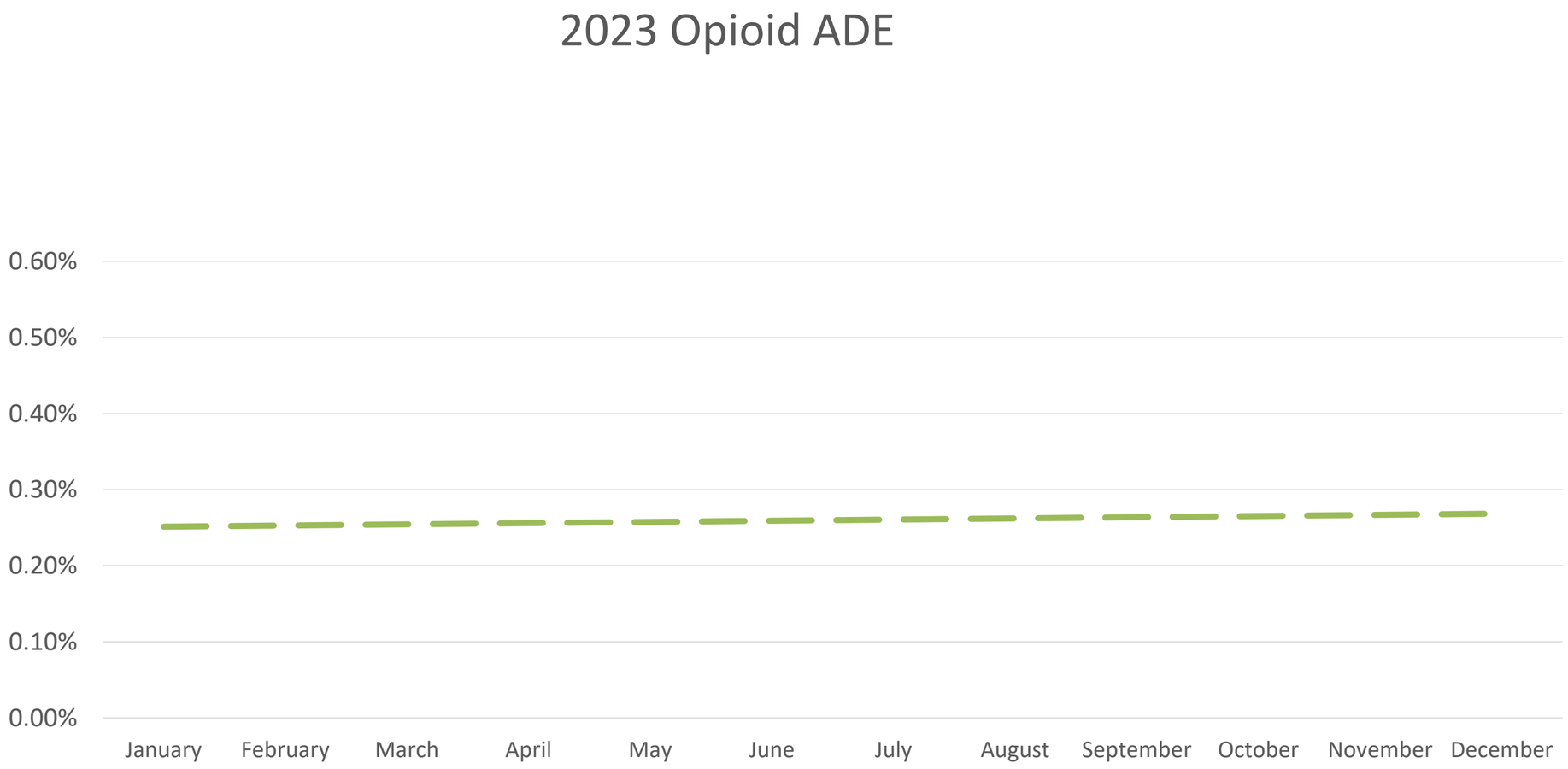
2023 Opioid ADE
0.60%
0.50%
0.40%
0.30%
0.20%
0.10%
0.00%
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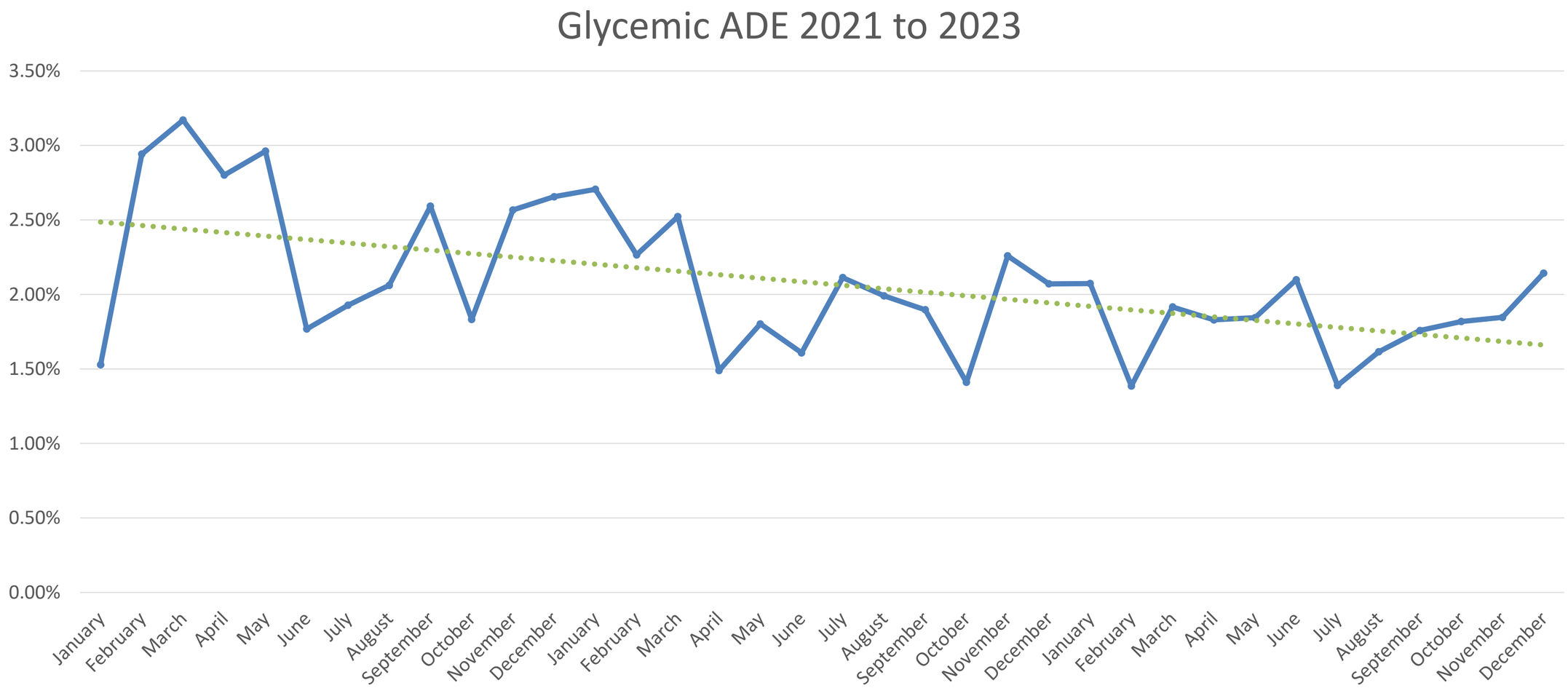
Data Review



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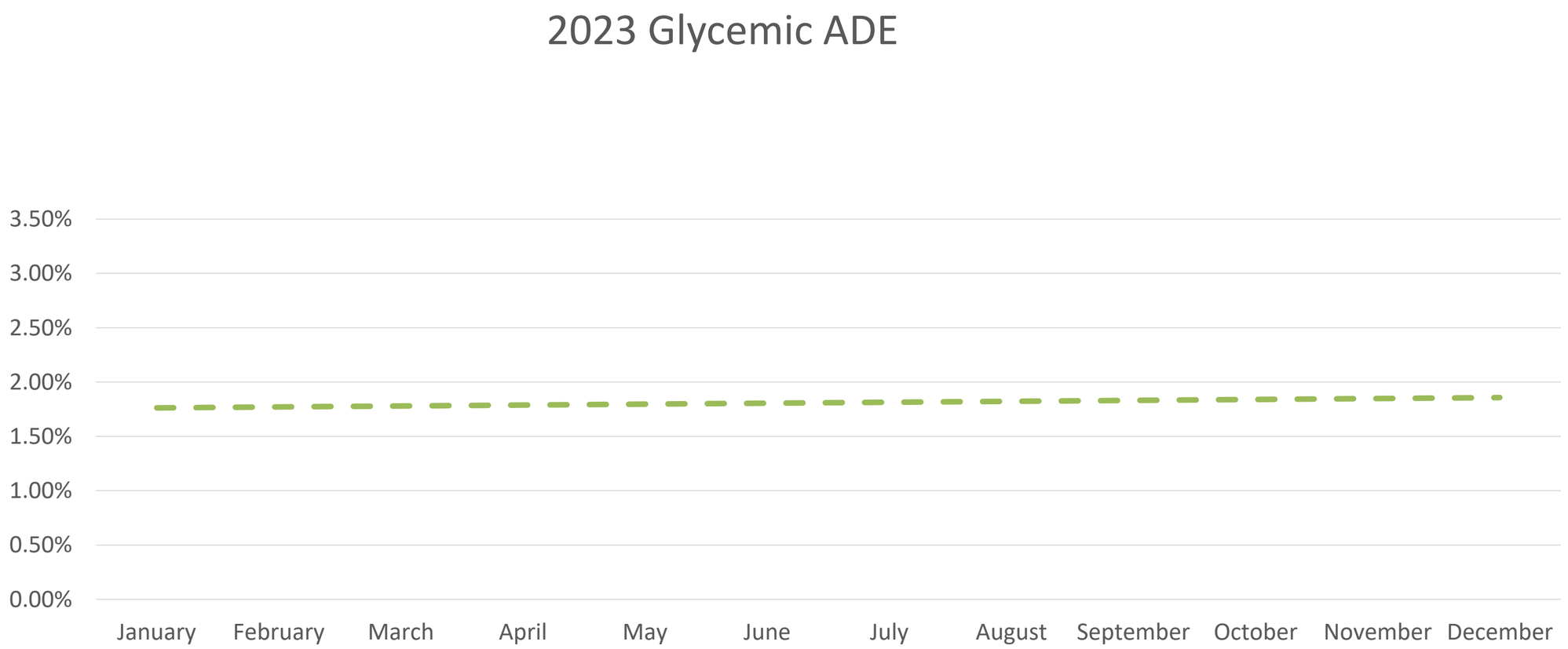
2023 Glycemic ADE
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
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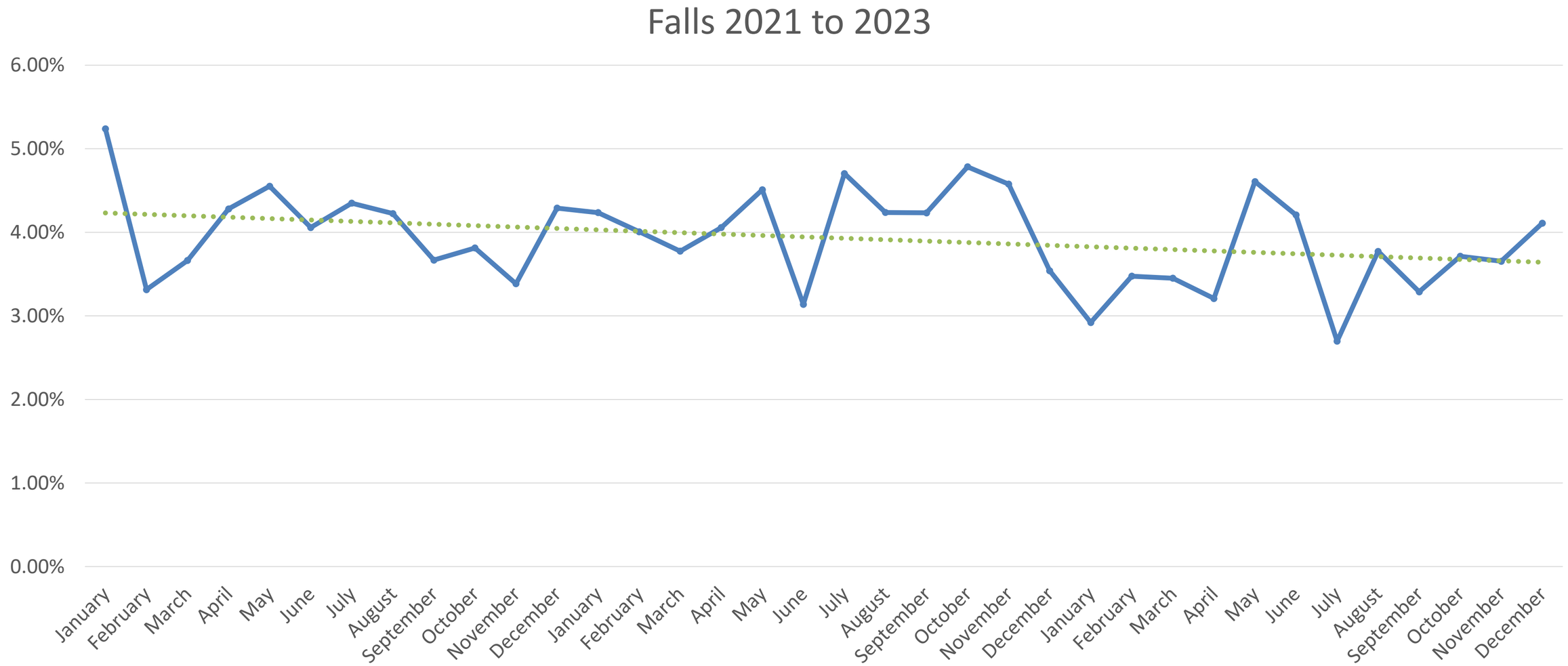
Data Review



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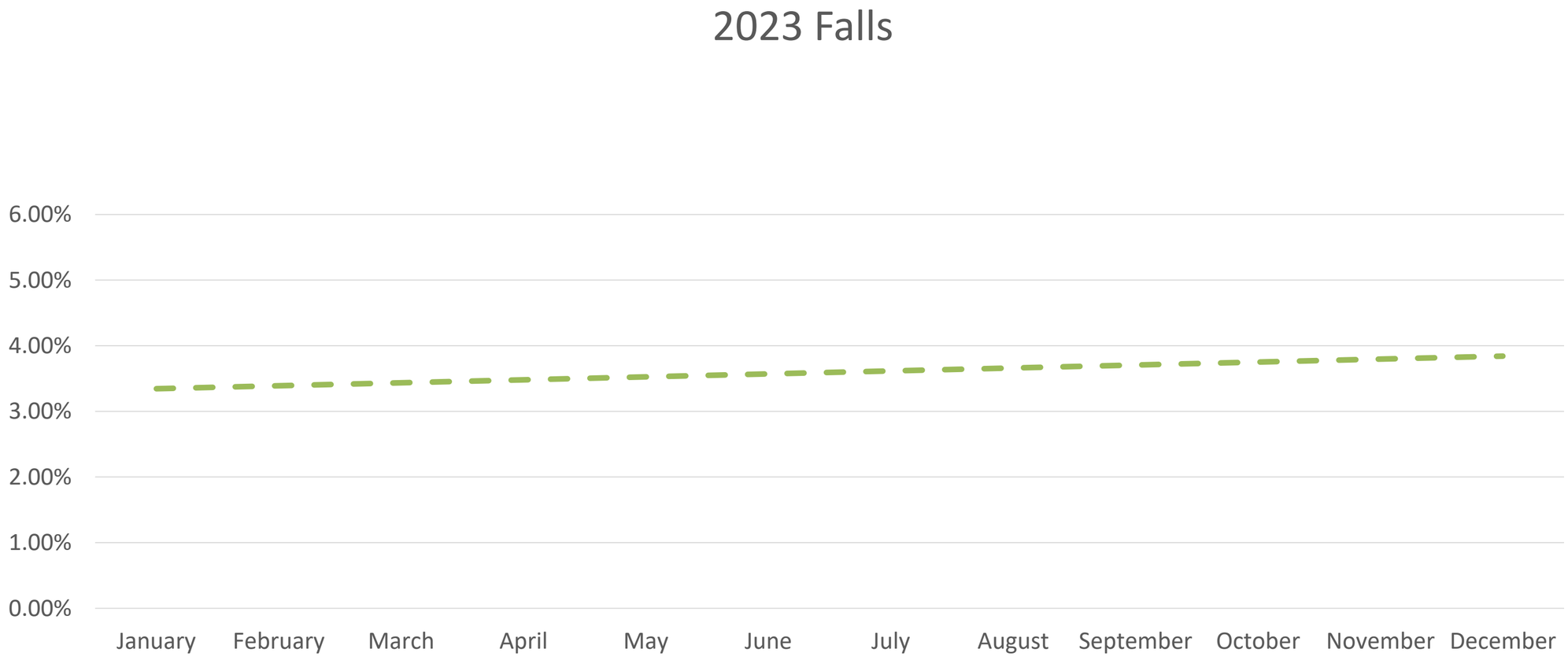
2023 Falls
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
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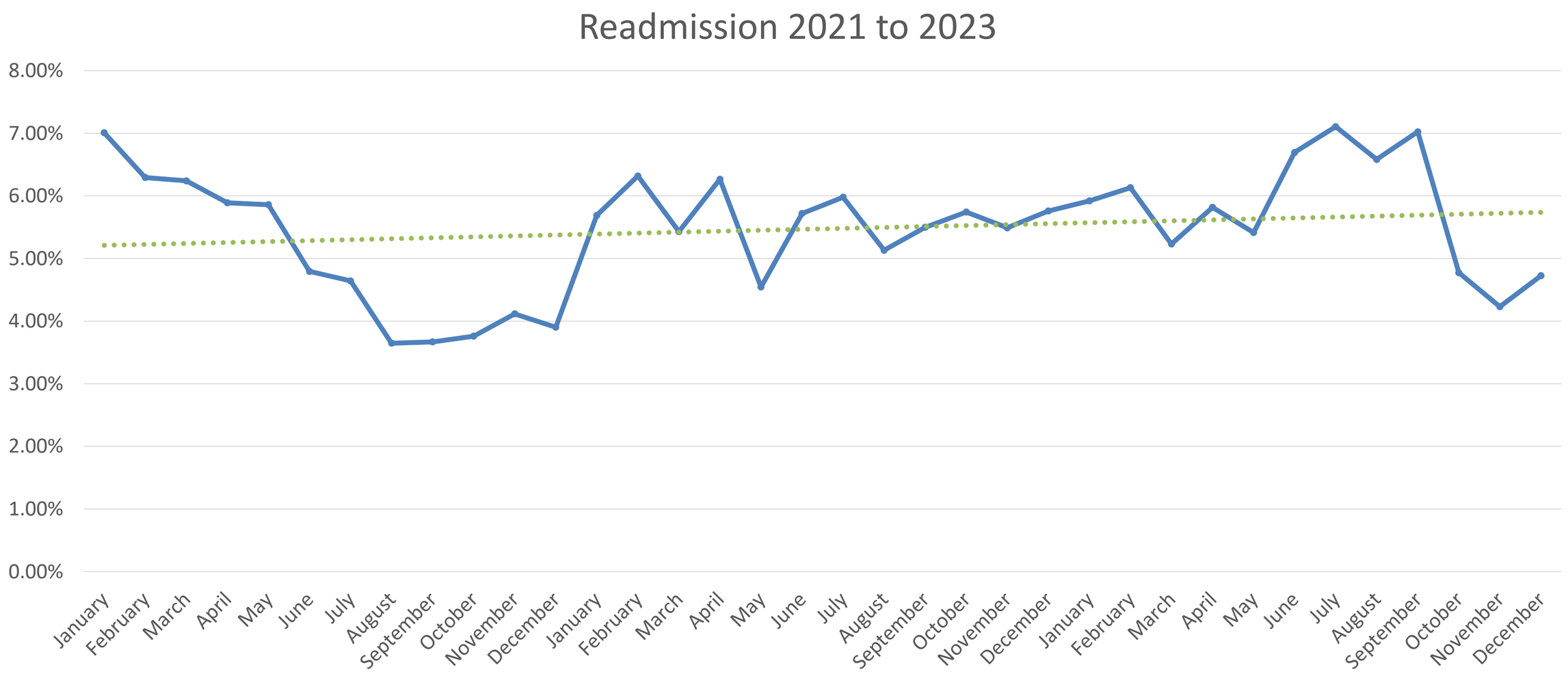
Data Review



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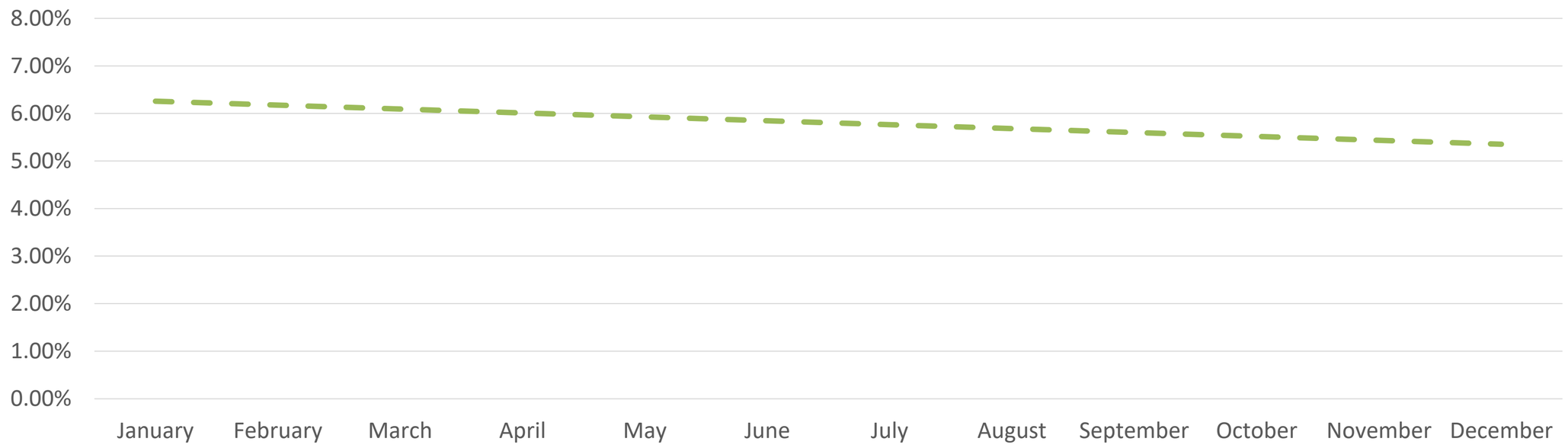
Data Review

2023 Readmissions



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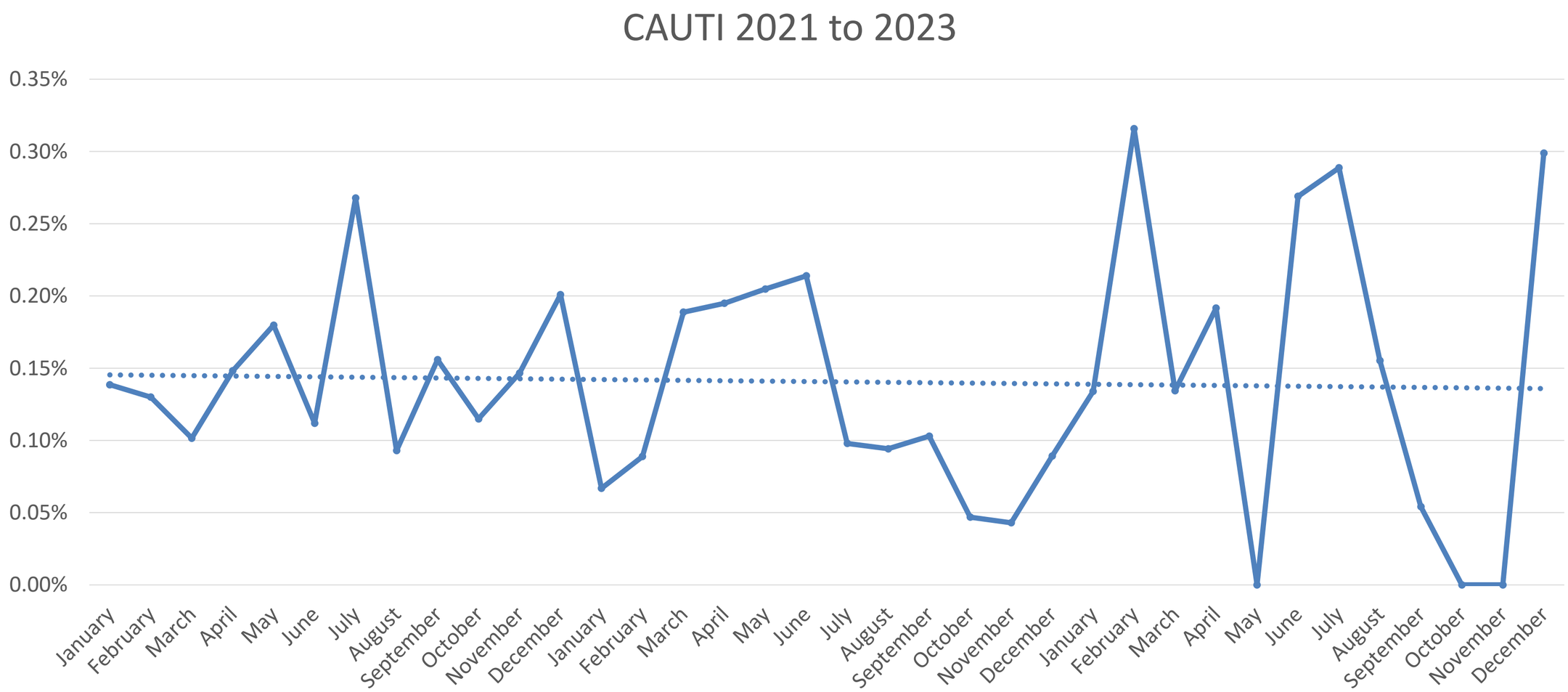

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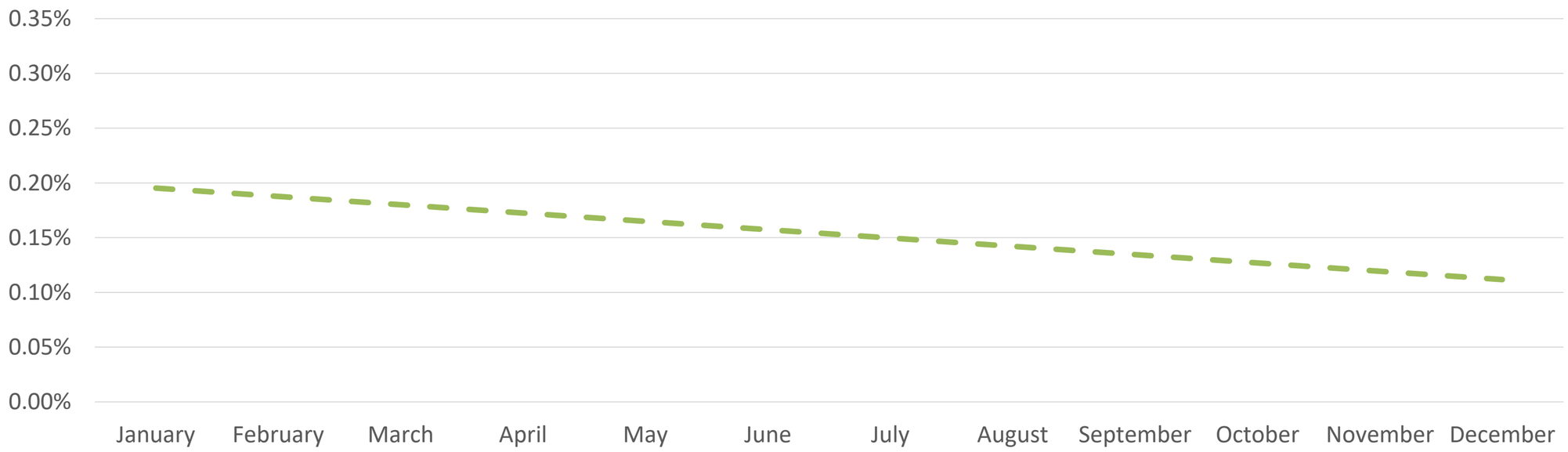
2023 CAUTI
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
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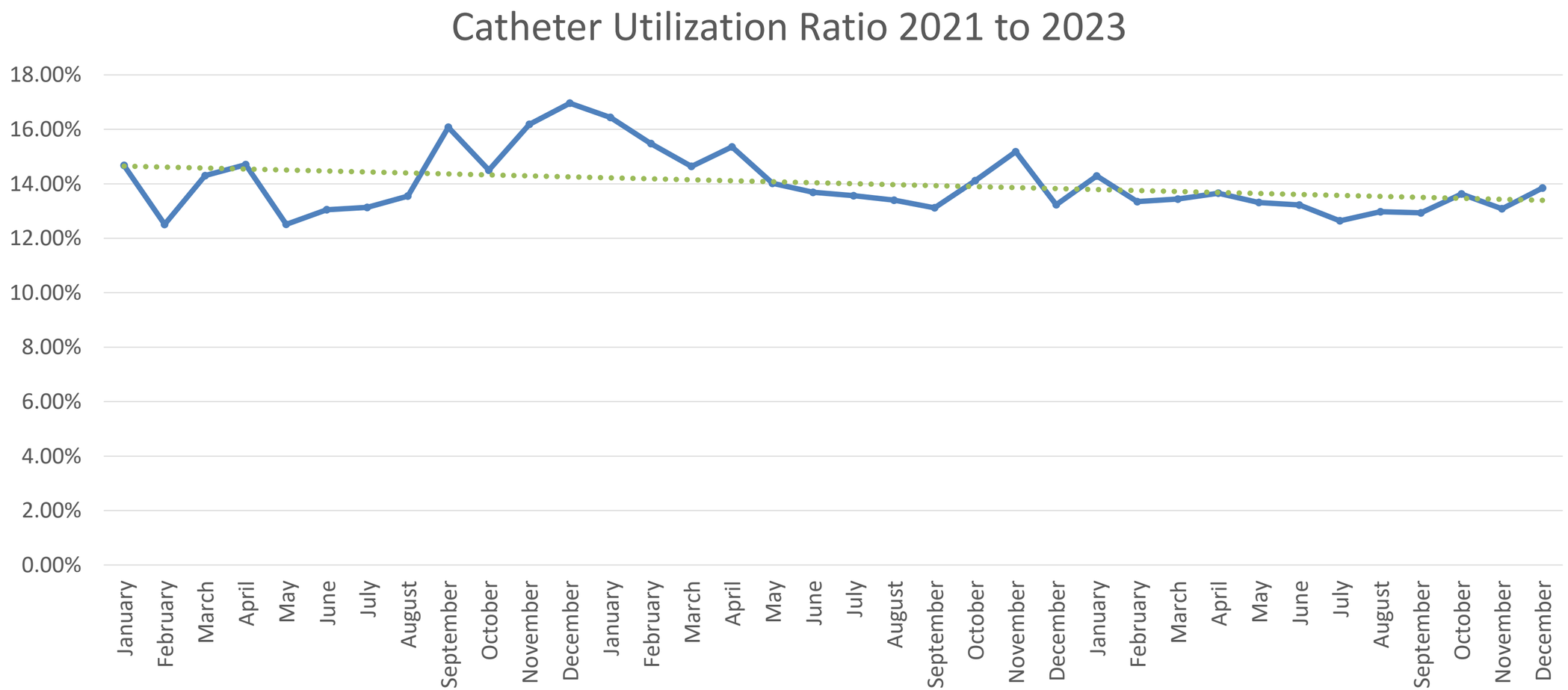
Data Review



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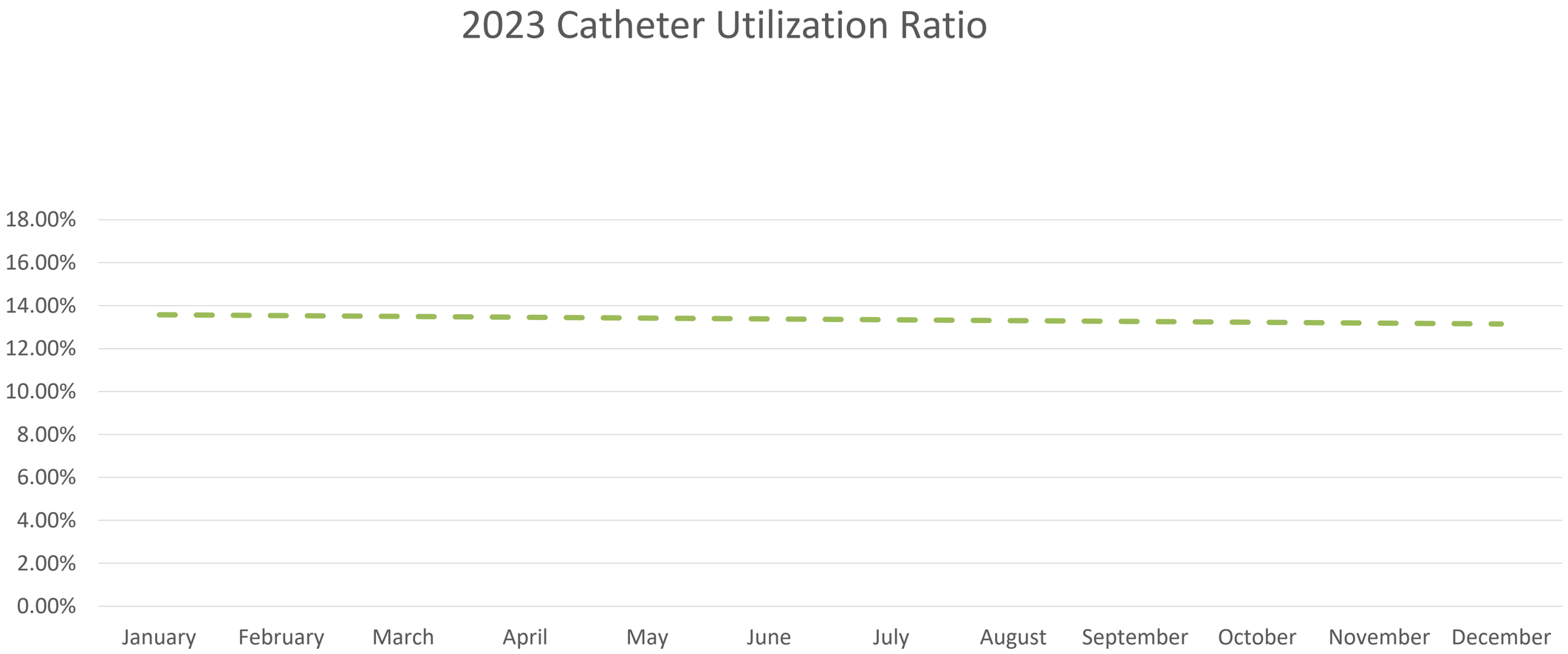
2023 Catheter Utilization Ratio
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
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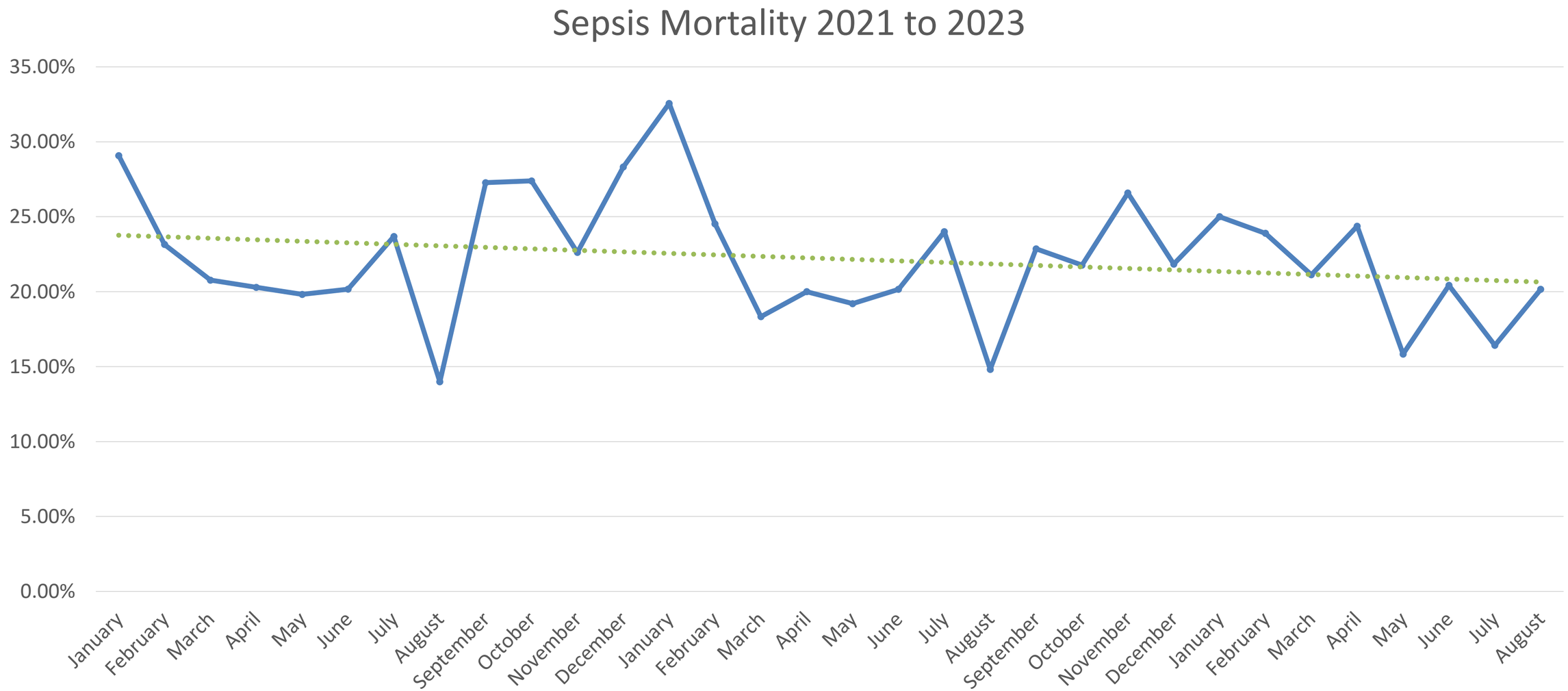
Data Review



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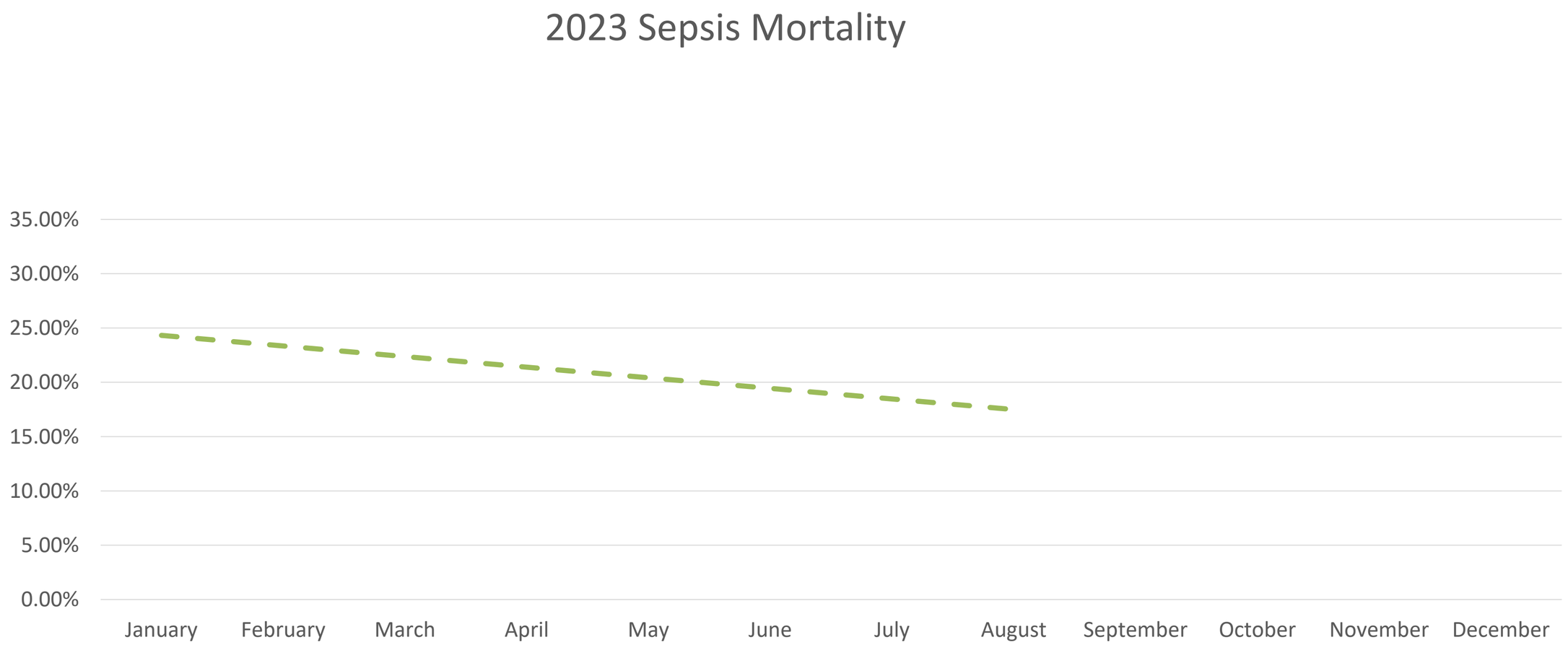
2023 Sepsis Mortality
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
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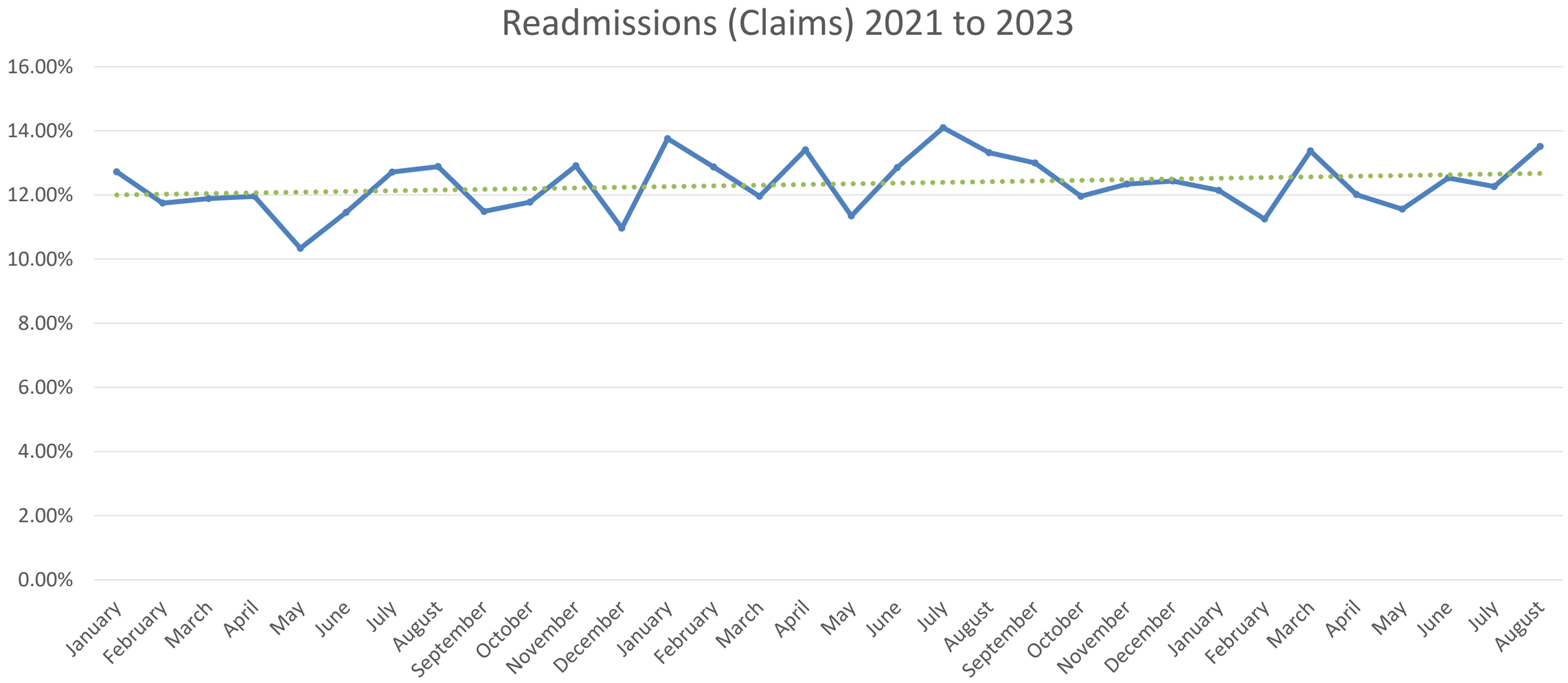
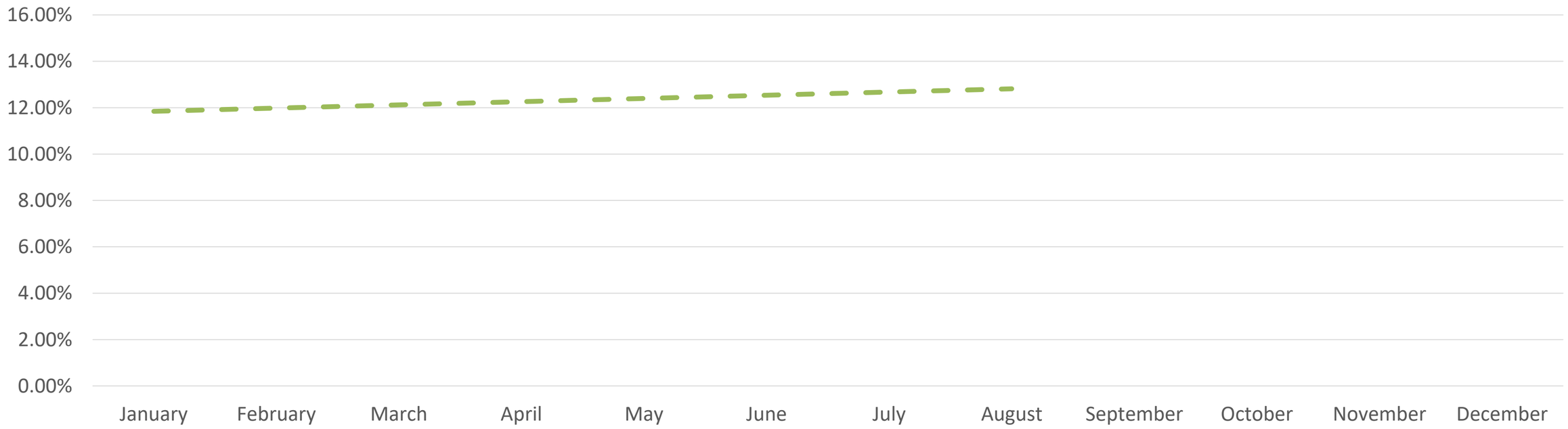
Data Review



Data Review

2023 Readmission Claims



Dimensions' REAL Data Submission

The NHA has began reviewing REAL Data submission for compliance. The following facilities had 100% compliance for 3 Q 2023:

- Genoa Community Hospital
- Ogallala Community Hospital
- Webster County Hospital
- Annie Jeffrey Health Center
- Osmond General Hospital
- Pawnee County Memorial Hospital

100% compliance not only includes submission of each patient visit, but also includes factors such as:

- Submitting identification of Race, Ethnicity, Age, and Language for all patients.
- Zero patients submitted with an "unknown" or "not reported" parameter.

The NHA will also be reaching out to facilities with high "unknown" identification markers to review processes and potential areas of improvement.

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13th Scope of Work Overview

CMS National Quality Strategy Goals

Equity

Advance health equity and whole-person care

Engagement

Engage individuals and communities to become partners in their care

Safety

Achieve zero preventable harm

Resiliency

Enable a responsive and resilient health care system to improve quality

Outcomes

Improve quality and health outcomes across the care journey

Alignment

Align and coordinate across programs and care settings

Interoperability

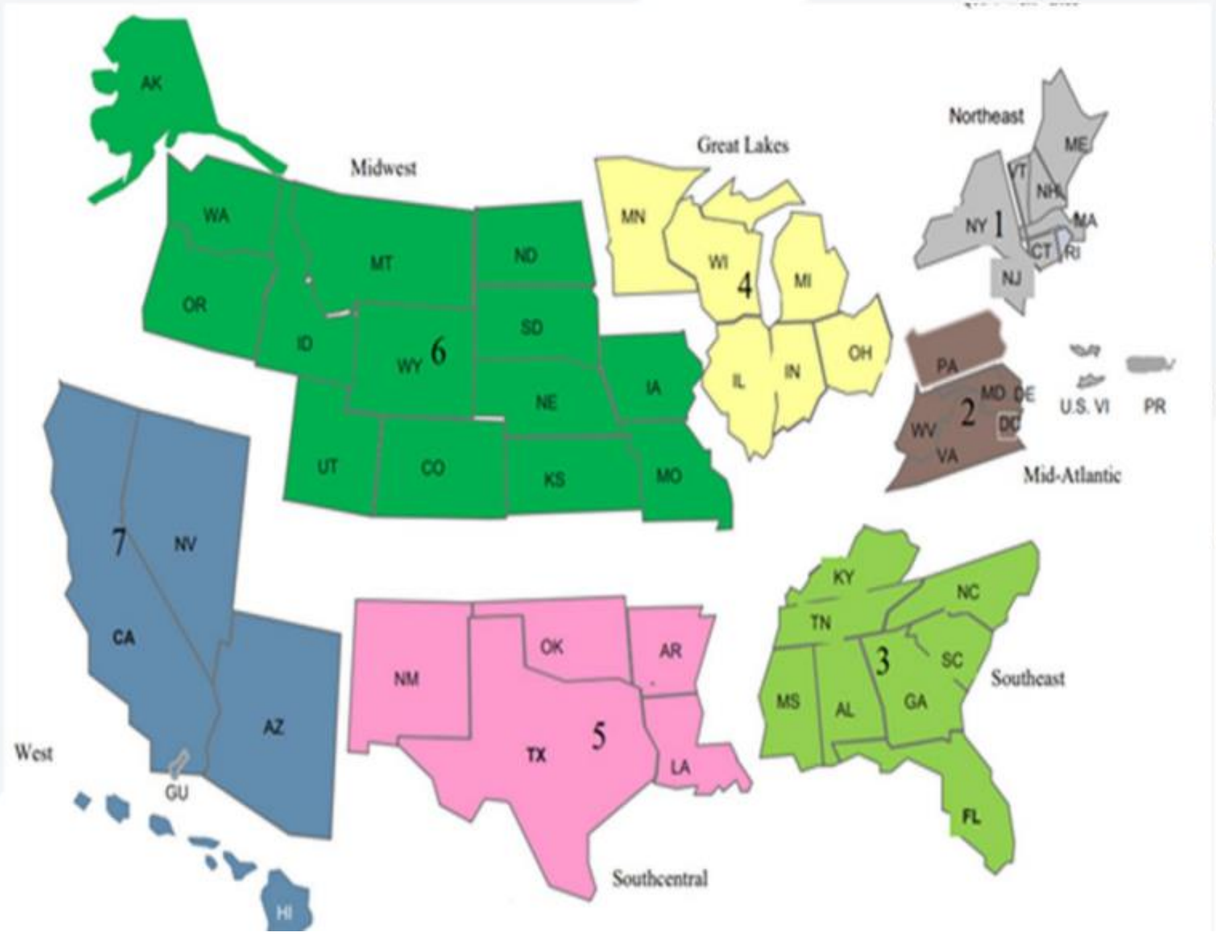
Accelerate and support the transition to a digital and data-driven health care system

Scientific Advancement

Transform health care using science, analytics, and technology

13th Scope of Work Overview

Integrated, Community-based Approach



- Total of 7 regions. Multiple states within a single region.
- Each state has multiple provider/facility types and communities.
- An award of one task order for each of the 7 regions.
- A QIN-QIO will be accountable for a region, inclusive of the identified member states, multiple provider and facility types and communities unlike 12th SoW where separate task orders were awarded for HQIC (hospital) and QIN-QIO (nursing home, community) work

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Compare 12th SOW to 13th SOW

- QI toolkit based on education, training, technical assistance
- Working along provider type/facility silos
- Some duplication of effort creating new materials that may already exist within the healthcare ecosystem, and providing assistance that other entities are able to provide
- All projects are pre-planned to meet CMS' assessment of provider needs
- Need to convince providers during enrollment phase, to join the QI program

- QI toolkit based on leadership coaching, RCQI, data analytics, digital tools, machine learning, AI
- Integrated, regional approach with responsibility for the community and providers within it
- AC3 Model: study environment and identify unique and most impactful role for QIO
- Some projects are deployed just-in-time to address emerging issues and are delivered in sprints (30-60-90 days), other projects are co-designed at the state and provider level for systemic QI
- QIOs seen as trusted national QI Experts and utilize a revolutionary provider engagement strategy based on value add that meets them where they are and serves critical needs

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Compare 12th SOW to 13th SOW

- Stakeholder engagement is layered on top of QIO work with providers, and primarily informational in nature
- TA primarily targeted towards facility's operational processes, workflows and middle management
- TA and education provided by QIOs, then coordination with other related entities takes place
- CMS heavily reliant on QIO program for stakeholder coordination, alignment and dissemination of information based on individual QIO model and approach
- Siloed and fragmented collaboration model between QIOs for sharing best practices during program implementation

- Stakeholders play key role in program design & implementation
- Influence organization at all levels starting with the C Suite and Governing Boards to drive e real change and prioritize quality and safety
- CMS leads and establishes national learning and communications coordination framework, QIO implement at local and state levels
- CMS plays leading role in stakeholder coordination and optimal socializing of the QIO capabilities to meet provider needs
- Technology-assisted, robust framework to build an effective learning community between CMS and QIOs, and between QIOs nationally

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CMS

CMS Priority Focus Areas for the 13th SoW QIN– QIO Program

1. Prevention & Chronic Disease Management

4 Sub-Aims

- Type 2 Diabetes
- Hypertension
- Chronic Kidney Disease
- Vaccinations

2. Patient Safety

3 Sub-Aims

- Infection Prevention and Control
- Safety Events
- Adverse Drug Events

3. Behavioral Health

3 Sub-Aims

- Depression and Suicide Prevention
- Substance Use Disorders
- Chronic Pain

4. Care Coordination

3 Sub-Aims

- Hospital 30-Day Readmissions
- Readmissions to Hospital from Skilled Nursing Facility
- Emergency Department Utilization

Foundational Aim 1: Quality Management Infrastructure and Emergency Preparedness

Foundational Aim 2: Advancing Healthcare Quality through Technology

Providers in need of assistance and those serving underserved populations (health equity), and those with limited access to resources

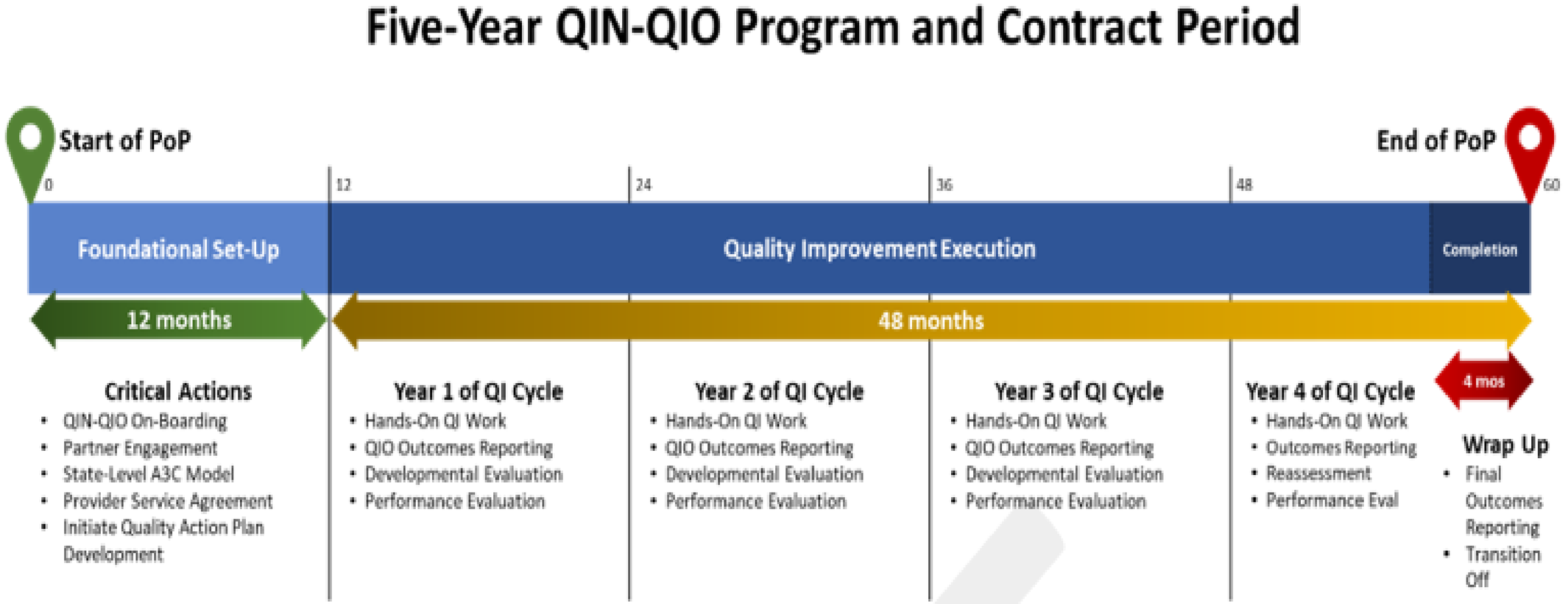

Figure 6: Five Year QIN-QIO program and Contract Period

NHA Updates

- **Process Precept**
  - McCook Session Registration Open – May 15

- **NHA Rural Health Conference**
  - June 3-5, 2024 – Kearney, NE

- **New Nurse Residency**
  - June 13-14, 2024 – North Platte, NE
  - Registration open NOW

Save the Date:

Vulnerable Populations Conference | September 19-20, 2024 | Lincoln, NE
NHA Annual Convention | October 16-18, 2024 | LaVista, NE
NHA CAH and RHC Quality Conference | November 14-15, 2024 | Kearney, NE

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MIDWEST Clinical Instruction REGIONAL NETWORK | University of Nebraska Medical Center Nebraska Medicine | NHA | NEBRASKA HOSPITALS

PROCESS PRECEPT:
Need to Know Skills Update

Wednesday, May 15, 2024
8 am - 4 pm | 6.0 contact hours

Community Hospital
1301 East H Street, McCook, NE 69001
Prairie View A Conference Room

REGISTER TODAY

Join your colleagues for case-based scenarios:
- Preceptor Roles
- Interprofessional Identity
- Teaching & Coaching Tools
- Action-Oriented Feedback
- Communication Strategies
- And more!

FREE

Intended for ALL nurses precepting!
Agenda
Amber Kavan, BSN, RN, CPHQ and Dana Steiner, BSN, MBA, CPHQ

8:00 a.m.	Registration
8:30 a.m.	Session 1: Harnessing 'Our Why' and 'How' as Preceptors
10:25 a.m.	Session 2: Creating Safety and Providing Support
12:00 p.m.	Lunch (Provided)
1:00 p.m.	Session 3: Using Teaching Prowess to Lead and Influence
3:15 p.m.	Session 4: Bringing It All Together: Using New Strategies in Practice
4:00 p.m.	Closing Remarks

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under 5T1QHP47311-02-00, Nurse Education Practice Quality and Retention: Clinical Faculty and Preceptor Academy, award totaling $3,995,519 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The University of Nebraska Medical Center designates this activity for 6.0 ANCC contact hours. Nurses should only claim credit for the actual time spent participating in the activity.

QUESTIONS?
MCIRN@unmc.edu

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Process Precept: Need to Know Skills Update

Save the Date: 2024 sessions

March 27 – Columbus, NE
May 15 – McCook, NE
June 26 – Grand Island, NE
July 10 – Atkinson, NE
Sept. 25 – Bridgeport, NE
Nov. 20 – Syracuse, NE

Registration details coming soon
Intended for ALL nurses precepting

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Questions?
MCRIN@unmc.edu

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NHA Updates

LB1087– Hospital Quality Assurance and Access Assessment Act

- Legislative bill introduced in January that focuses on additional Medicaid funds through federal CMS programming.
- Background:
  - In 2016, CMS authorized Directed Payments through MCOs and allowed up to average commercial rates.
  - 44 states have a hospital assessment supporting rates.
  - $1 invested by state or provider assessment is matched about $2.19 by Fed.
- Goals:
  - Improve operating margins by reducing Medicaid losses to preserve health care services across Nebraska.
  - Establish a partnership with state to pursue maximum allowable federal reimbursement for Medicaid.

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NHA Updates

LB1087– Hospital Quality Assurance and Access Assessment Act

- Key Principles:

CMS

- No hold harmless on assessments paid.
- Assessment must be uniform and broad-based.
- Increases can be uniform percent increase, min fee schedule, or value-based.
- Must be tied to state's Medicaid quality strategy.

Quality Metrics

- SDOH screening
- Post-partum depression screening in the hospital
- CAUTI

Supplemental Metrics

- ED Behavioral Health Use
- Age-Friendly Spread

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Approved Initial Measures

Measure	Numerator	Denominator	Notes
Complete a screening for Social Determinants of Health (SDOH).	Number of adult patients (>=18 y/o) admitted inpatient to the hospital that receive a SDOH screening that includes each of the five health related social needs (food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety) during each hospital stay. ■ Only fully complete screenings will be considered applicable.	Total number of inpatient admissions.	■ Screening can occur any time during the hospital admission prior to discharge. ■ Screening should occur during each hospital stay. ■ Only unique patients should be included in any, one reporting period (year). ■ If a patient has multiple admissions in the year, the most recent result (i.e., the result closest to the reporting period) should be submitted. ■ Recommend hospitals use discharge date for inclusion into the denominator. ■ The following patients would be excluded from the denominator of both measures: 1) Patients who optout of screening for any reason; and 2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. ■ Additionally, patients who expire during the inpatient stay are excluded. ■ Hospitals will send the NHA quarterly progress reports that will only be used internally to track progress. An annual final submission for the calendar year will be obtained for CMS review.
Maternal Post-partum depression screening.	Number of delivering mothers that receive a depression screen after delivery before discharge.	Total number of delivering moms.	■ Use of recognized screening tool that addresses anxiety. ■ Examples: Edinburgh Postnatal Depression Scale (EPDS) Edinburgh Postnatal Depression Anxiety Subscale (EPDS-3A) Patient Health Questionnaire 9 (PHQ-9) with Generalized Anxiety Disorder Screener (GAD-7)
CAUTI	Number of CAUTI infections	Number of catheter days	■ NHSN or self-reported ■ Follow CDC / NHSN definition ■ For those with a designated ICU – ICU CAUTI and Med Surg CAUTI will be reported separately both adult and pediatric

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Approved Initial Measures

Measure	Numerator	Denominator	Data Source
Complete a screening for Social Determinants of Health (SDOH).	Number of adult patients (>=18 y/o) admitted inpatient to the hospital that receive a SDOH screening that includes each of the five health related social needs (food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety) during each hospital stay. ■ Only fully complete screenings will be considered applicable.	Total number of inpatient admissions.	▪ Self-Reported – EHR Report
Maternal Post-partum depression screening.	Number of delivering mothers that receive a depression screen after delivery before discharge.	Total number of delivering moms.	▪ Self-Reported – EHR Report
CAUTI	Number of CAUTI infections	Number of catheter days	▪ NHSN or ▪ Self-Reported

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Potential Goals and Benchmarking

Measure	Current Benchmark	Potential Goal
Complete a screening for Social Determinants of Health (SDOH).	NA	35% by the end of 2025. 55% by the end of 2026. 80% by the end of 2027.
Maternal Post-partum depression screening.	66% November 2023 per NPQIC data	71% by the end of 2025. 75% by the end of 2026. 80% by the end of 2027.
CAUTI	0.743 SIR for All Locations 1.152 SIR for Acute Hospitals (non-ICU)	0.7 by end of 2025

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NE Age-Friendly Health Systems Growth Goals:

Current Number of AF Organizations	Growth in Year 1 = Increase by 50%	Growth in Year 2 = Increase by 25%	Growth Year 3 = Increase by 25%
26	39	49	61

Add requests for continued engagement and data submission with the program.

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Top 9 Diagnosis Groupings by Prevalence:

Dx Group	Percent of Visits
Alcohol Related Disorders	20%
Anxiety and Fear Related Disorders	19%
Depressive Disorders	14%
Suicidal Ideation / Attempt / Intentional Self-Harm	13%
Schizophrenia Spectrum and Other Psychotic Disorders	7%
Trauma and Stressor Related Disorder	5%
Bipolar and Related Disorders	4%
Other Specified and Unspecified Mood Disorders	4%
Stimulant Related Disorder	3%

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AHA Patient Safety Initiative

National initiative to boldly reaffirm hospital and health system leadership and commitment to patient safety.

The three foundational issues that will be focused on in 2024 include:

- Fostering a culture of safety from the board room to the bedside
- Identifying and addressing inequities in safety
- Enhancing workforce safety

- Spans over multiple years

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Quest for Excellence Award:

- Recognizes outstanding work in hospital quality and performance improvement
- Partners include: State of Nebraska, the Nebraska Hospital Association, Nebraska QIO, COPIC, the Nebraska Health & Human Services' Office of Rural Health and the Nebraska Association for Healthcare Quality, Risk and Safety
- Presented to two Nebraska hospitals (CAH and Non-CAH) and one Rural Health Clinic each year to recognize their achievements in improving health care delivery in the areas of quality, performance, and patient safety.
- Created in 2004 to recognize hospitals' individual and independent efforts, the award is designed to showcase innovative, exemplary, and reproducible models of patient care to the health care community.

- Applications Due: August 1, 2024
- Link for Past Submissions: Quest for Excellence Award : Engage with NHA : Quality and Safety : Nebraska Hospital Association (nebraskahospitals.org)

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Goal Setting

Session 2

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Learning Objectives

- Understand why is goal setting important
- Learn basics on goal setting
  - AIM Statement
  - SMART goals – SMART-ER Goals
- Target v. Target Conditions
- Delineate use of stretch goals

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Key Steps in Goal-Setting:

Benchmarking: evaluation of the current status of the practice, understand performance internally, understand how peers are performing

Risk Adjustment: know realistic targets, state necessary and available resources, acknowledge factors that will affect success, understand potential unintended consequences

Target: Set appropriate targets based on current knowledge

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Know Where You are Headed…

AIM Statement

How will you know a change is an improvement?

Timeframe, ***amount*** of expected change of ***population or denominator*** will ***desired outcome***.

By February 2021, 25% of nursing staff in Blue County Hospital will be trained in the “Crucial Conversations" curriculum.

Practice: Hospital X has seen decrease in barcoding prior to administration of meds being given in the Emergency Department in Q1 2021.

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Know What You are Measuring…

Measurement

- Outcome Measure: An endpoint, measure of effect - a measure which is used to assess the effect, both positive and negative, of an intervention or treatment. i.e.: a fall

- Process Measure: specific steps in a process that lead — either positively or negatively — to a particular outcome metric. i.e.: bed alarms usage

Know the Specifics…

Measures – SMART Objectives

- ✓ What changes can you implement to achieve the AIM?
  SMART or SMARTER
  - **S**pecific
  - **M**easurable
  - **A**chievable
  - **R**elevant
  - **T**ime-bound

Original Objective	How Can we Improve?	SMART-er Objective
Staff will be trained in Quality Improvement.	Need to clarify the who and the what and the timeframe.	Blue County Hospital will offer Quality Improvement training opportunities resulting in 75% of staff completing the training by December 31, 2020.

Practice: ED staff will be trained on barcoding process.

- ✓ SMART – ER Objectives:
  - Specific
  - Measurable
  - Achievable
  - Relevant
  - Time-bound
  - **E**valuated
  - **R**eviewed or revised

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Steps to Making Change

PDSA

- PLAN: team, AIM, Objectives, examine current process, describe the problem
- DO: implement action plan created in step 1 – be sure to collect data and document problems, unexpected effects, general observations
- STUDY: Use AIM and Data to determine effectiveness – improvement, trends, unintended side effects
- ACT: If the plan worked → standardize / spread it – if the plan did not work start over at Plan

Pushing the Limits

- Definition: a target that is intentionally designed to be challenging to attain.
  - Used to counter the common tendency of teams to set conservative goals that are easy to meet
  - Often set in conjunction with a regular target goal
  - Failure to meet a stretch goal is not viewed ‘negatively’ but meeting it is exceptional.

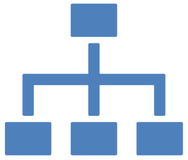
Stretch Goals

Pros:

Can motivate

Move teams out of a rut

Encourage organizations to dream big



Cons:

Can also demotivate

Lead to poor / inconsistent reporting

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Example of a Stretch Goal

Target: To increase provider communication HCAHPS score to above the 90th percentile.

Stretch Goal: 90% of patients that complete an HCAHPS Survey will rate our hospital a 10 for overall care

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Unintended Consequences of Change Management:

- Unanticipated or unforeseen outcomes of a purposeful action
- Can be positive or negative
- Need to be aware and assess processes for unintended consequences
- Negative Example:
  - Strict isolation for COVID-19 patients
    - Intended outcome: decreased spread
    - Unintended outcome: increased falls
- Positive Example:
  - Hourly Rounding:
    - Intended outcome: decreased falls
    - Unintended outcome: increased patient and family satisfaction

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Return on Investment (ROI) in Quality / Cost-Benefit Analysis

Session 2

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ROI or CBA or Both?

Return on Investment (ROI) and Cost Benefit Analysis (CBA) are both methods of measuring the financial benefits of investment.

ROI: Calculation of the most tangible financial gains or benefits that can be expected from a project v. the costs for implementation of the suggested program / equipment / solution.

ROI is an accounting model.

CBA: More comprehensive than ROI, attempts to quantify both tangible and intangible ("soft") costs and benefits, taking into account all groups affected by the proposed investment.

CBA is an economic model.

There are benefits and drawbacks to each model.

A third option is to combine the two:

ROI + CBA = Good Strategic Decision-Making

Throw in Cost Effectiveness Analysis

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Calculating ROI

- An ROI is calculated as the ratio of two financial estimates:

ROI = Net financial returns from improvement actions / Financial investment in improvement actions

- Where the numerator and denominator of this ratio are defined as follows:
  - *Net financial returns from improvement actions* -- The financial gains from the implementation of the improvement actions, which are generated by net changes in quality, efficiency, and utilization of services, or in payments for those services.
  - *Financial investment in improvement actions* -- The costs of developing and operating the improvement actions.
- Considered an educated estimate

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Calculating CBA

- Build the structure: Know where you are, what change you are specifically looking to make, and what will be required to make the change.
- Determine the stakeholders: Determine who will be impacted by the change, who will bear the costs, and who will obtain the benefits.
- Categorize the costs and benefits: Categorize and classify costs and benefits as direct, indirect, tangible, and intangible in order to determine their effects clearly.

- List the costs as a monetary value – difficult to give value to intangibles.
- List the benefits as a monetary value

- Evaluate the results

➢ Compares the cost of an intervention to its effectiveness measured in natural health units
  - Costs: Monetary Unit
  - Consequences: Natural units (Years of life saved, cases prevented)

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Let's Walk Through the Process:

Step #1: Determine the Basic ROI / CBA Design

4 Design Decisions

1. **Define the scope of services affected by the improvement actions:**
   a) **Unit Affected:** One unit (e.g., the emergency department) and others will have a broader scope (e.g., across all nursing units).
   b) **Scope of Services:** Define the scope of services to be included in the ROI calculation and ensure that financial estimates are specifically related to that scope of services.
2. **Define the timeline for implementation of improvement actions:**
   a) Could be as short as a few months or as long as years.
   b) Capture when actions change the hospital's operating procedures over time-- to estimate the implementation costs and the financial effects of improvement actions
3. **Define the comparison group:**
   a) Numerator for the ROI ratio -- compare the hospital's finances under 2 conditions:
      1. With the improvement actions implemented – after improvement
      2. Without them – before improvement.
4. **Capture complete information on financial contributors**:
   a) Identify and quantify as many of the financial contributors as possible for both the numerator and denominator of the ROI formula.
   b) Best estimates of improvement action costs and of the components of net returns.

   ***post-implementation ROI, you will have actual data from your financial system on those contributors.

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Let's Walk Through the Process:

Step #2: Calculation

- Create Estimates
  - *Net returns from the improvement actions* (the ROI ratio numerator) / *Implementation costs* (the ROI ratio denominator)
  - Money you are saving or revenue you are creating / how much money went into implementation

- Returns:
  - 2 types of financial effects:
    - Operating costs
      - reducing its infection rates -- eliminate the costs from extra care required to treat infections.
      - Enhance or protect revenues -- incentives or penalties
- Costs:
  - Equipment
  - Training
  - IT
- **Cost Savings Calculation:** "How much did we save?"
- *The cost savings is the difference between returns and costs:*

Cost Savings = Worksheet 2 Total (returns) – Worksheet 1 Total (investment)

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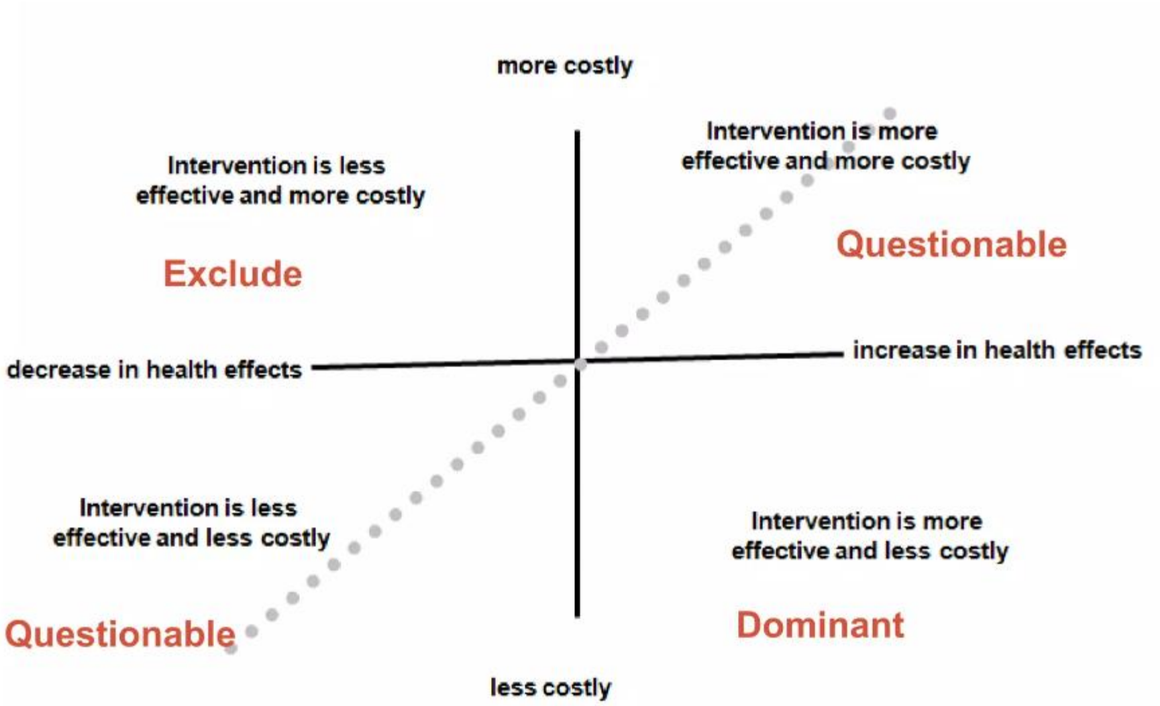
Let's Walk Through the Process:

Determination of Costs:

Cost analysis for each project consideration should include both direct and indirect costs:

- Direct Costs: Specifically linked to health interventions
- Cost Expenditures: Associated with adverse events or negative outcomes
- Cost Savings: Accrue as a result of improved health outcomes



- Costing non-market items
  - Volunteer's time
  - Family of patient's waiting time
  - Loss of sleep
  - Leisure of patients

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Let's Walk Through the Process:

Table 1. Categories of Costs Incurred at Different Stages of Implementing a Practice or Quality Improvement Program

Cost Category	Stages of the Improvement Actions				
	Planning and Development	Training	Startup	Ongoing Operation, Monitoring, and Maintenance	Shutdown
Personnel	X	X	X	X	X
Supplies	X	X	X	X	X
Equipment			X	X	
Training	X	X	X	X	
Information systems			X	X	X
Outreach and communication			X	X	X
External consultant costs		X	X	X	

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Let's Walk Through the Process:

Step #3: Interpret the Findings

- *ROI greater than or equal to 1*:
  - Returns generated by improvement are greater than or equal to the costs for development and implementation.
  - ROI is considered to be ***positive***.
  - For example, an ROI of 1.8 indicates that for every $1 you invest in the quality improvement program, $1.80 will be gained for the hospital.
- *ROI less than 1*:
- Improvement actions yield a net loss from changes in quality and utilization.
- ROI is considered to be ***negative***.
- For example, an ROI of -1.5 indicates that for every $1 invested, $1.50 will be lost by the hospital.
- An ROI of 0.8 indicates that for every $1 invested, 80 cents will be recouped by the hospital -- the hospital loses 20 cents for every $1 it spends on the quality program.

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An Example:

Hospital Sunshine is contemplating purchase and implementation of fall prevention video surveillance.

- 25-Bed Critical Access Hospital with ADC of 9
- Falls: 2019 – 6 falls, 2020-14 falls, 2021 – 15 falls, 2022 – 14 falls, 2023 – 12 falls
- Cost of Falls ($65,000 / fall x 12 falls) = $780,000
- 3% operating margin

Costs / Investments	Amount
Start-up / Implementation / Equipment Cost	$39,000
Monthly Upkeep Costs ($1,000 / month)	$12,000
Training Costs (100 staff members x 8 hours x $40 / hour)	$32,000
Cost of Falls ($65,000 / fall x 12 falls	
Total Cost Investment	$83,000

Benefits / Returns	Amount
Decreased Fall Rate ($65,000 cost of a fall from 12 falls to 6 falls)	$780,000-$390,000 = Savings of $390,000
Decreased Staff time spent on patient oversight ($40 / hour cost decreased from 200 to 150)	$8,000 - $6,000 = Savings of $2000
Improved Patient and Family Engagement and Satisfaction	$25,000
Total Cost Investment	$421,000

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Returns / Investments

=

ROI / CBA / CEA

Returns $421,000 / Investments $83,000

=

5.07

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Project Management at Work

Session 2

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Learning Objectives

- Describe project selection, planning, and implementation
- Explain how to best evaluate the success of a project

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WHY Project Management?

- Increased regulation
- Decrease costs of care – eliminate waste
- Workforce shortage
- Efficiency
- Improve quality of patient care
- Staff engagement
- Patient satisfaction
- And so much more…

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Defining Project Management

- Project
  - A temporary endeavor undertaken to create a unique product, service or result.
- Project Management
  - The application of knowledge, skills, tools, and techniques to project activities to meet the project requirements.
- Project Manager
  - Person assigned by the performing organization to achieve the project objectives.
- Scope Management
  - Includes the processes required to ensure the project includes all of the work required to complete the project successfully
- Integration Management
  - Includes the processes and activities needed to identify, define, combine, unify and coordinate the various processes and project management activities within the project management process groups.

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WHAT is Project Management?

- Applies knowledge, tools, skills, and techniques to accomplish project activities, ultimately achieving the organization's goal

- Project Management in the Health Care Industry
  - Hospitals
  - Health Systems
  - Clinics
  - Insurance Companies
  - Pharmaceutical Companies
  - Health Care Vendors

All of these rely on you!

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HOW do I Manage Projects?

- Resource Allocation
  - Time
  - Funding
  - Tools
- Communication
  - Shared mental model across departments
  - Organization
- Productivity
  - Improve workflows
  - Reduce waste

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Roles as a Project Manager

- Develop and manage the budget
- Manage issues and risks
- Conduct meetings to review project status
- Maintain project information
- Facilitate conflict resolution
- Assist with time management to assure timely completion and meet deadlines
- Use resources to organize and manage the team

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Stages of Project Management

1) Initiation – Kick-off Meeting
   - Define the scope and create achievable goals and objectives
   - Understand costs, anticipated risks, and desired outcomes
2) Planning
   - Break it down
   - Assign roles
   - Establish deadlines
3) Execution and Monitoring
   - Get to work
   - Repeated PDSA cycles
4) Conclusion
   - Review outcomes and deliverables after project is finished
   - Any lessons learned

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Key Skills for Project Management

- Adaptability
- Leadership
- Problem-Solving
- Communication
- Relationship Building

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Building a Project Charter

- Helps identify appropriate scope, deliverables, and team
- Serves as a contract for senior management, stakeholders, and sponsors
- Keeps teams focused on the deliverables
- Demonstrates how projects support, aligns, and delivers your organization’s strategic objectives
- A project charter should always be done

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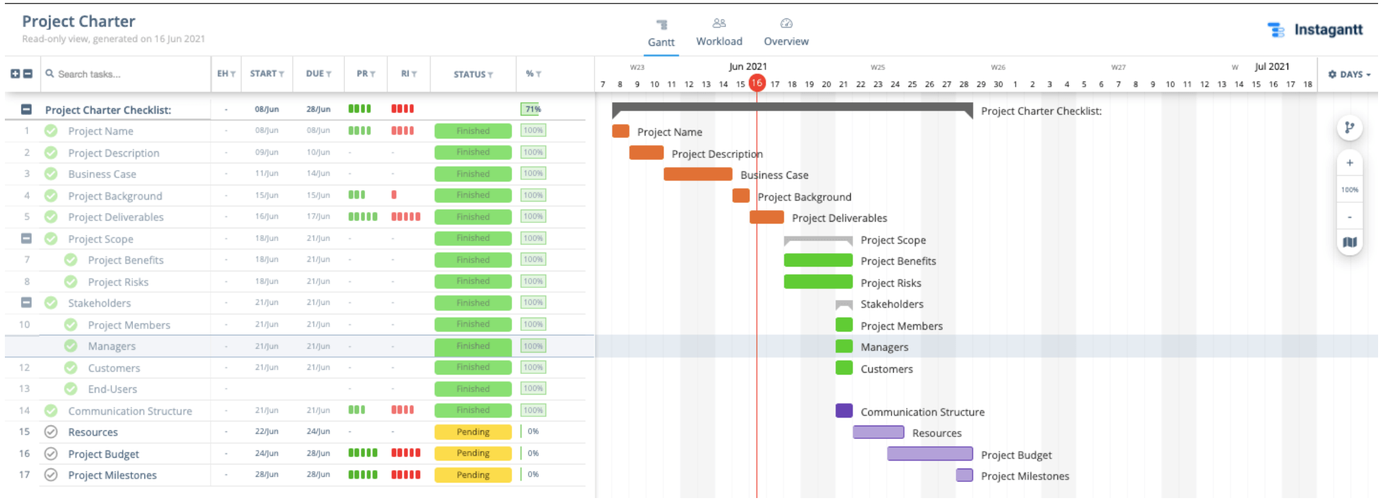
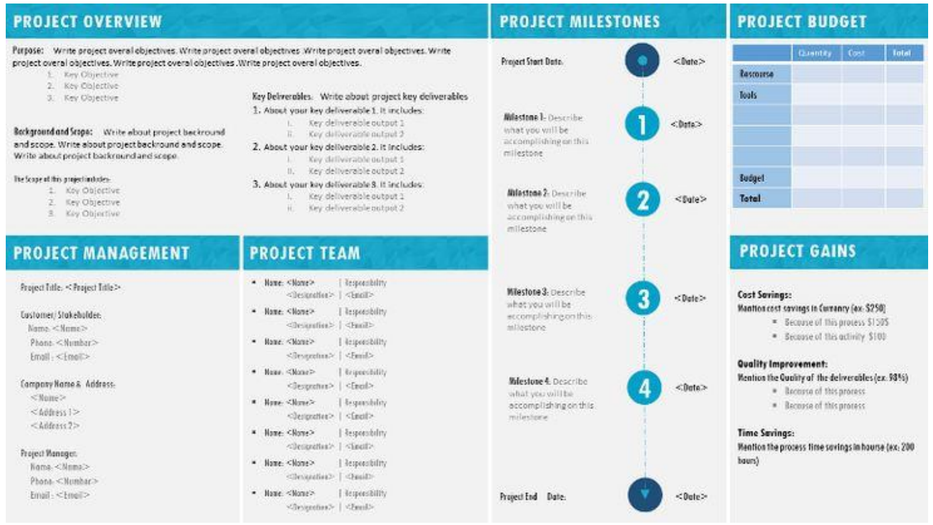
Building a Project Charter

Project Charter			
Project Name:			
Business Case:			
Problem/Opportunity:		**Scope, Constraints, Assumptions:**	
Goal:		**Team Members:**	
Preliminary Project Plan:	**Target Date:**	**Actual Date:**	
Define			
Measure			
Analyze			
Improve			
Control			
Prepared by:		**Approved by:**	





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Challenges to Project Management in Health Care

- We are dealing with patients lives
- Heavy regulation
- Increasing costs
- Constantly in flux
- Excessive stakeholder oversight

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How to Prioritize when EVERYTHING is a Priority

- When everything is a priority, nothing is
- Review mission, vision and values
- Who are you targeting?
  - Staff
  - Patients
  - Families
- What are you targeting?
  - Quality of care
  - Service
  - Patient Safety
  - Outcomes
  - Throughput
  - Cost
  - Access
  - Equity

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Steps to Help Drive Quality Improvement

1) Understand your data
   - What is your source of truth
   - Identify where you will yield the most benefits

2) Identify improvement priorities using the 80-20 rule
   - Identify 20% of care processes that 80% of resources consume

3) Gain consensus from clinic teams on specific projects and goals
   - Determine the root cause of potential variations

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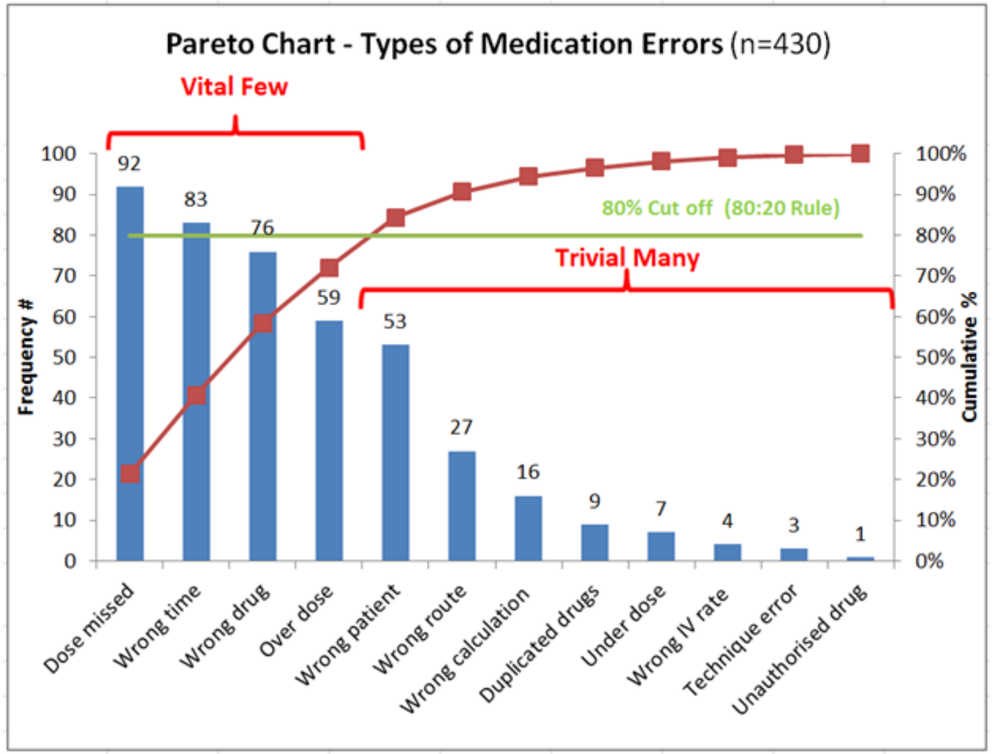
Pareto Chart = Prioritization

- A type of chart that contains both bars and a line graph, where individual values are represented in descending order by bars, and the cumulative total is represented by the line
- Focus on the “Vital Few” to reach your desired outcome



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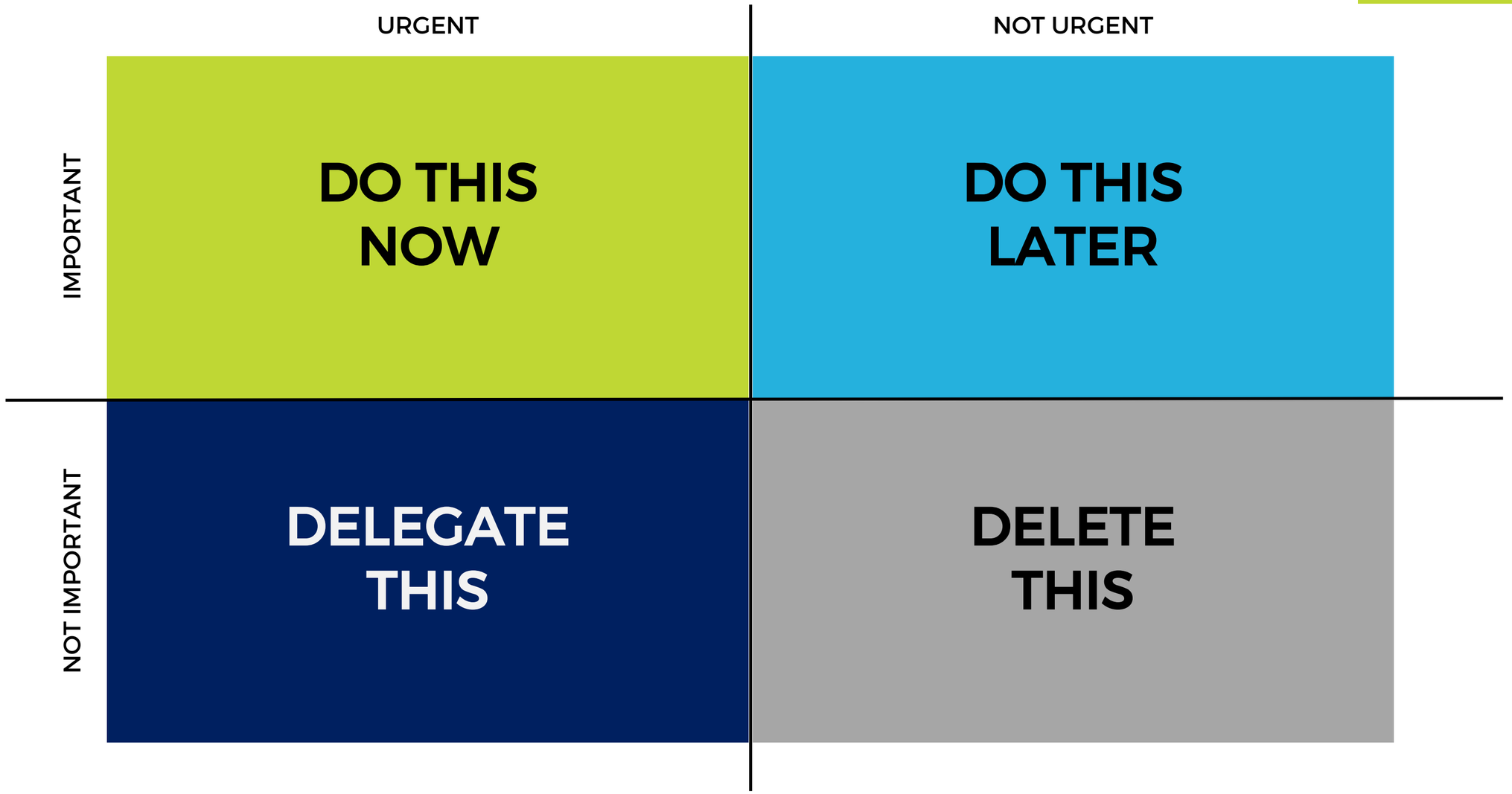
Project Prioritization Matrix



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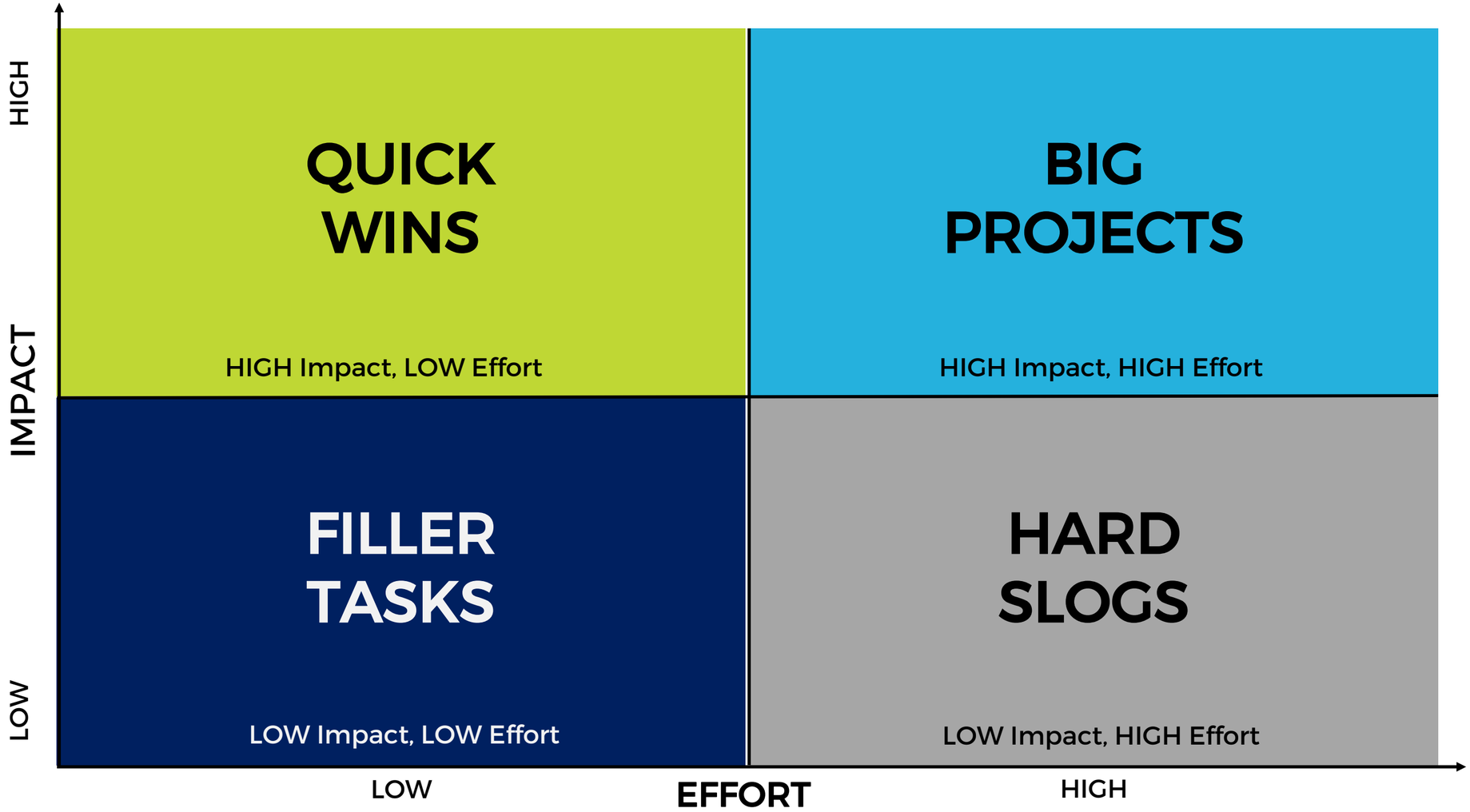
The Action Priority Matrix



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Not Another Meeting...

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Who Benefits from Project Management

- Patients → sense of being heard and understood
- Teams → increased collaboration and team spirit
- Organizations → more effective use of resources
- YOU!!!!!!! → increased professionalism, visibility, credibility, improved time management and organization

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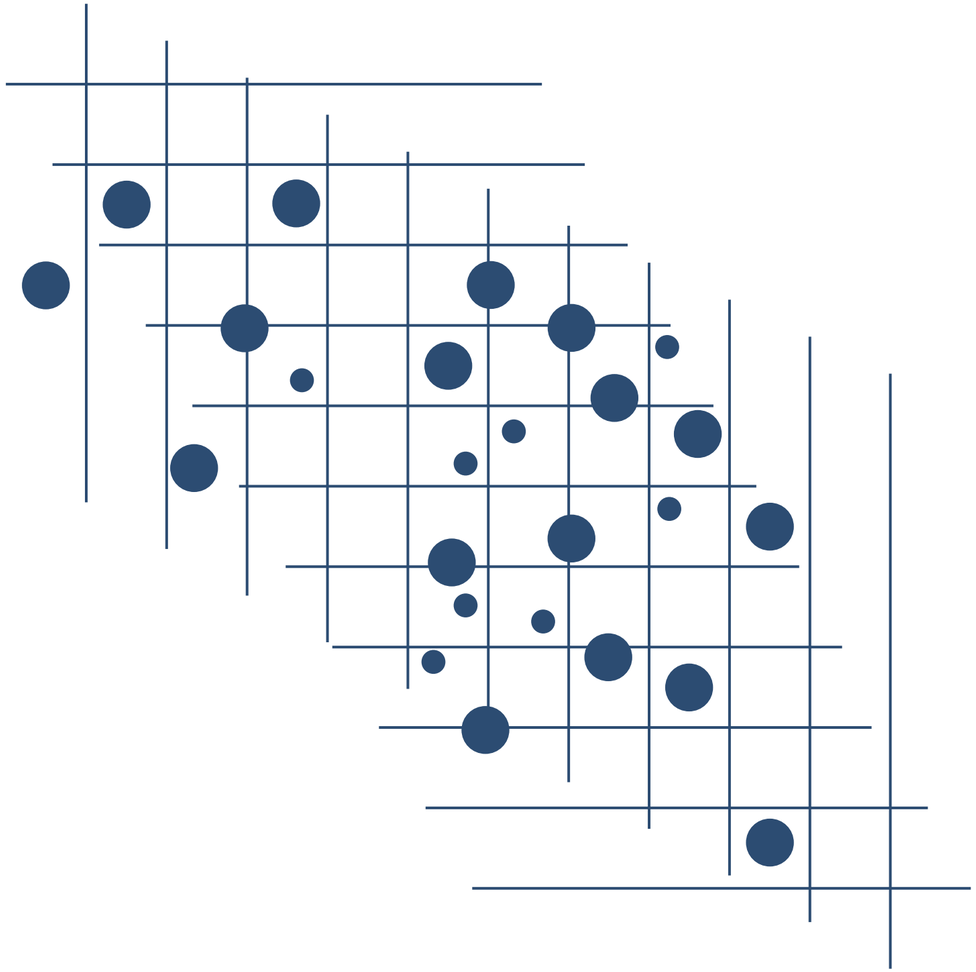
Let’s Test your Knowledge!



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Certifications to Support YOU!

- Certified Professional in Health Care Quality | CPHQ
- Certified Associate in Project Management | CAPM
- Project Management Professional | PMP
- Program Management Professional | PgMP
- Lean Six Sigma | Brown, White, Yellow, Green, Black, Master Black

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Let's Talk About your Capstones

Session 2

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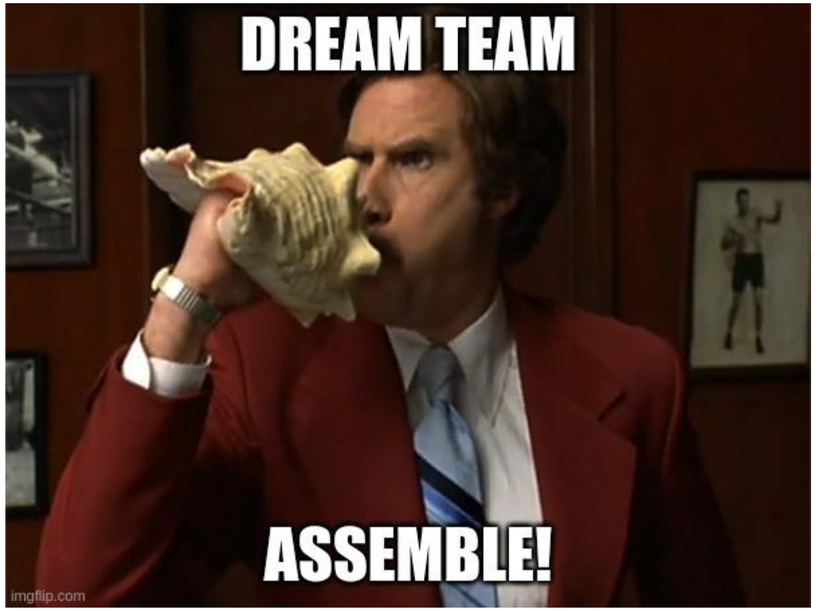
Brainstorming Topics

Who is on your team?

- Project Champion
- Frontline Staff
- Provider
- Quality
- Risk/Safety
- C-Suite
- Other key stakeholders



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Building your AIM Statement

S	Specific	Identify the exact process you are targeting, including what/who is included or specifically excluded.	
M	Measurable	Identify at least one or more specific measurement that will tell you change was an improvement.	
A	Attainable	Ensure the improvement can be completed in the time allotted with the resources available.	
R	Relevant	Ensure the project is strategically aligned and the appropriate parties are accountable for the work.	
T	Time-Bound	Always include the deliverable or end date.	

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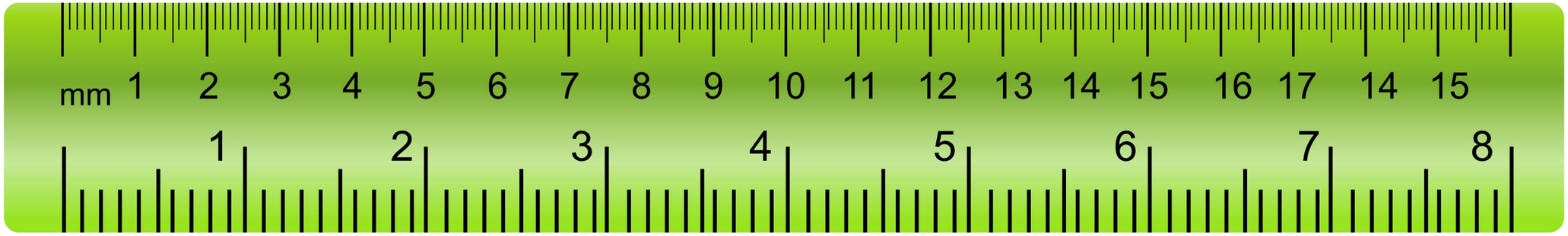
What are you Measuring?

- Quality metrics – falls, readmissions, HAI's, etc.
- Workflows
- Efficiencies
- Patient satisfaction
- Insurance denials
- Bundle compliance
- You can measure anything!



Measure What Matters

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Selecting Changes

- Interventions to support change

Ability
Education
Training
Communications
Guidelines
Policies
Procedures

Motivation
Education
Incentives
Persuasion
Modeling
Policies

Opportunity
Enablement
Guidelines
Autonomy
Workflows

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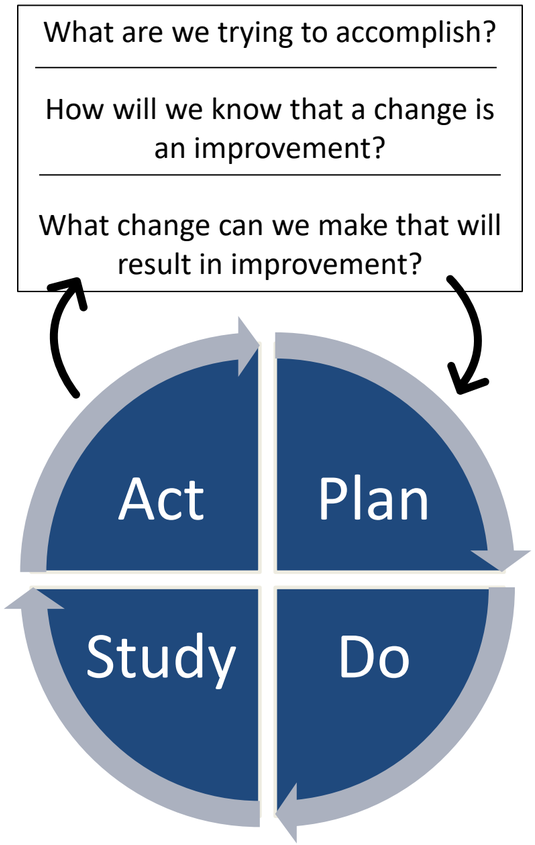
PDSA Cycle



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What Data do you Plan to Collect?

Collect → Monitor → Track → Trend → Visualize

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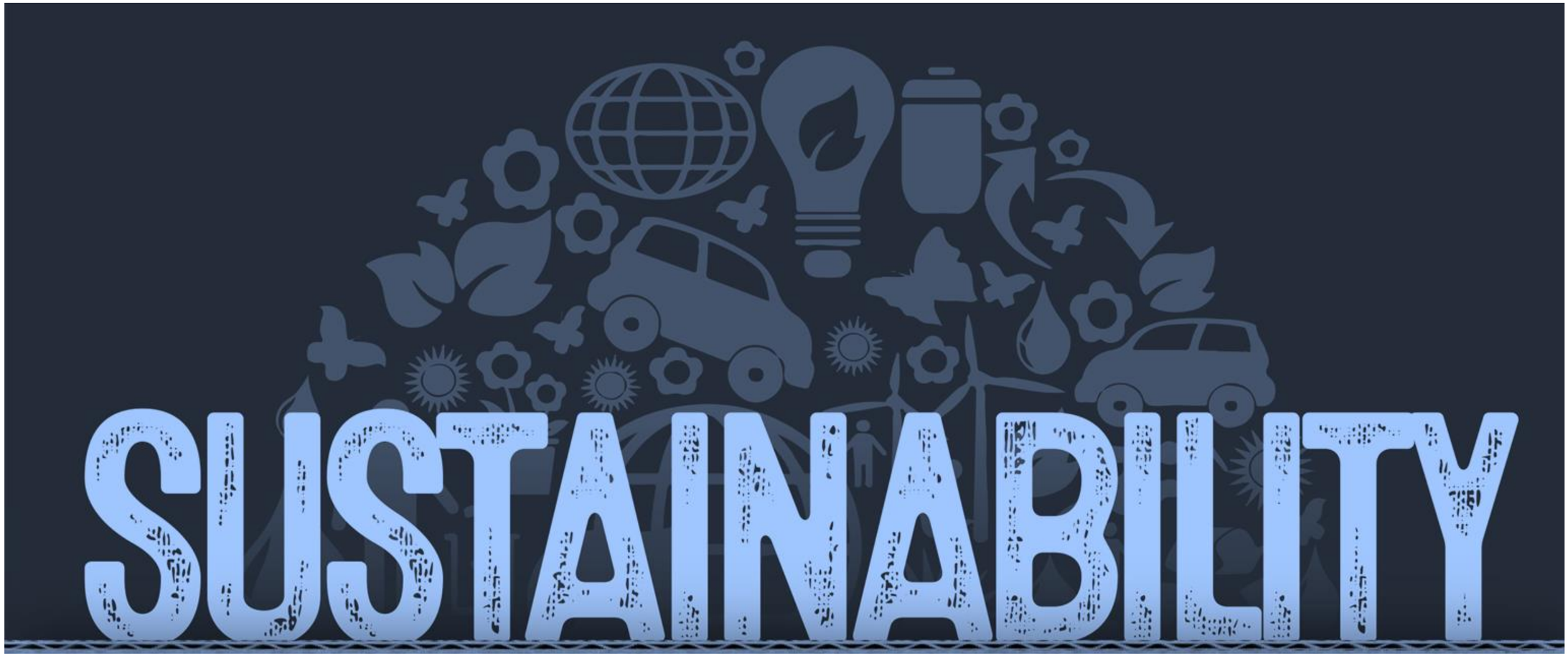
Spreading Change



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Next Session

Grand Island Regional Medical Center | Grand Island
June 27-28

- Optional Hospital Tour Day 2
- Connect with your mentor

Our Great Team

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