# Hospital IQR Quality Reporting Program

## Support Contractor

## Specifications Manual, Version 4.4a, Changes & Hospital VBP Program Improvement Series

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**Matt McDonough:** Good morning, everybody, and thank you for joining us for today's webinar on [the] Specifications Manual.

My name is Matt McDonough. I'm going to be your webinar host for the day.

As you can see on your screen the audio is available via streaming of computer audio. You do need your speakers to listen-in today. Obviously, if you hear my voice, you are doing so, and that's wonderful.

We are going to have a wonderful program today with a number of speakers that will be bringing you some great information. But, before we start on that, we want to give you a heads-up on how you can submit your questions to our panelists today. Obviously, there are no phone lines, or very

few phone lines, and one-way audio over computer speakers doesn't enable you to speak. So, how are you going to submit questions to our panelists today? Well, you're able to submit your questions via the chat window which you'll locate on the left side of your screen. In that chat window you can type your question in and click “Send.” That question will go to all of our presenters. All of our presenters on the line today will see that, and we will provide you - if we have any answer – we'll provide you with an answer via the chat window. Obviously some questions we may not be able to answer today, but we will be archiving and addressing all questions after this event today.

So please do - if you have questions, please do submit them via that chat window so that we can get you an answer, if at all possible.

That's going to do it for my introduction today. So, I am going to hand over to Deb Price who will begin today's presentation.

Deb, the floor is yours.

**Deb Price:** Hello, and welcome to our IQR and Value-Based Purchasing monthly webinar. My name is Deb Price and I am your host for today's webinar.

Before we begin I'd like to make a few announcements.

The first one: this program is being recorded. A transcript of the presentation along with the Qs&As will be posted to our new Inpatient Web site at www.qualityreportingcenter.com. They will also be posted to the *QualityNet* site at a later date.

Two: if you registered for the event, a reminder email, as well as the slides, were sent to your email an hour ago.

And, finally, three: if you didn't get that email, you can download the slides from the new Inpatient site at www.qualitynet – www.qualityreportingcenter.com.

The purpose of today's webinar is to provide a high-level overview of changes to version 4.4a of the Specifications Manual, and to provide an improvement - to provide improvement stories of the Hospital Value-Based Purchasing Program MSPB measure.

The objectives of today's webinar are to identify chart-abstracted measures required for the IQR program, to identify

interventions, to improve their MSPB ratios, and to discuss MSPB improvement plans with other hospital providers.

And now I'd like to introduce our first speaker, Candace Jackson. Candace is the Inpatient Quality Reporting Program Support Contractor Lead for the Hospital Inpatient Value Incentives and Quality Outreach and Education Support Program. Boy, that's a whole – there's a handful there.

Candace, the floor is yours.

**Candace Jackson:** Thank you, Deb.

Today we will be going over the changes to the Specifications Manual for National Inpatient Quality Measures version 4.4a with some additional guidance from the original version, 4.4, which is effective for January 1, 2015 through September 30, 2015 discharges.

Although we will be going over the changes, we will not be able to answer specific abstraction questions on today's call. If you have specific abstraction questions, those should be submitted to the Q&A tool on *QualityNet*.

Next slide, please.

Beginning with January 1, 2015 discharges, AMI-2 and AMI-10 have been removed from the Specifications Manual. For CMS, AMI-1, AMI-3, AMI-5, AMI-7, and AMI-8 will remain as voluntary measures. AMI-8a has been removed from the IQR program and now will be voluntary. Hospitals can voluntarily submit these measures to the CMS Clinical Warehouse. AMI-7a will be required for the IQR program.

Next slide.

There have been no changes to the AMI initial patient population. The initial patient population continues to be all patients with an ICD-9-CM principal diagnosis code of AMI, a patient age greater or equal to 18 years of age, and a length of stay less than or equal to 120 days. You will continue to identify your AMI initial patient population and abstract those cases for AMI-7a, even if you do not provide fibrinolytics, or if no fibrinolytics were administered.

For example, if there were 100 patients that met the criteria for the AMI initial patient population, commitment sample size will

be 78 cases. If you do not administer fibrinolytics, you will still abstract and submit those 78 cases for AMI-7a. As fibrinolytics were administered, the cases will be excluded from [the] measure denominator. Otherwise, they will result in a measure outcome of B. However, you will still submit those 78 cases to the CMS Clinical Warehouse to meet the submission requirement.

Next slide, please.

Due to AMI-2, we have removed from the Specifications Manual the data elements “aspirin prescribed at discharge” and “reason for no aspirin at discharge” were also removed from the manual. There were no elements specific to AMI-10 removed from the manual, as those elements are also used in other measure sets.

Next slide, please.

All references to left bundle branch block were removed to reflect the latest ACCF/AHA STEMI guidelines, which no longer support left bundle branch block as criteria for acute reperfusion. Changes were made to the data elements “initial ECG interpretation” as cases with an initial ECG finding of a "Not a STEMI" should be excluded from the reperfusion measures.

Next slide, please.

For heart failure, as it's no longer collected by the IQR program, Heart Failure 1 and Heart Failure 3 were remove for the aligned Specifications Manual. In addition, Heart Failure 2 will no longer be required for the IQR program beginning with January 1, 2015 discharges. It has been made a voluntary measure. Hospitals can voluntarily submit Heart Failure 2 to the CMS Clinical Warehouse, but are not required to submit it.

Next slide, please.

As Heart Failure 1 was removed from the Specifications Manual, the discharge data elements listed here in the slide that were no longer relevant to that measure has also been removed from the manual.

Next slide, please.

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For pneumonia, beginning with January 1, 2015 discharges, PN-6 will be a voluntary measure for CMS, as it has been removed from the IQR program. Hospitals can voluntarily submit PN-6 to the CMS Clinical Warehouse, but are not required to submit this measure. In addition, PN-3a and PN-3b have been removed from the Specifications Manual.

Next slide, please.

With the removal of PN-3a and PN-3b, the data elements, “blood culture collected,” “initial blood culture collection date,” and “initial blood culture collection time” were also removed from the manual.

Next slide

For SCIP, SCIP-Inf-10, which has been a voluntary measure for CMS, has been removed from the manual. In addition, SCIP-Inf-1, SCIP-INf-2, SCIP-Inf-3, SCIP-Inf-6, and SCIP-Inf-9, SCIP-Card-2, and SCIP-VTE-2 have been removed from the IQR program. As such, for discharges beginning with January 1, 2015, these measures can be submitted voluntarily, but they're not required to be submitted to the CMS Clinical Warehouse. SCIP-Inf-4 will continue to be required for the CMS Inpatient Quality Report in the IQR program.

Next slide, please.

With the removal of SCIP-Inf-10, the patient age check for patients greater or equal to 18 years of age was moved from the major level into the SCIP initial patient population. The SCIP topic population is now all patients with a principal procedure on Table 5.10, patient age greater or equal to 18 years of age, and a length of stay less than or equal to 120 days.

There has been no change to the reporting of the SCIP population and sampling for each of the eight strata. Hospitals will continue to identify and report the population size and sample size for each of the eight strata. That means hospitals will continue to abstract and submit cases that qualify for each of the eight strata even though they may not meet the major denominator of SCIP-Inf-4, which is a specific group of cardiac surgery patients.

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As I just stated, SCIP-Inf-4 is Cardiac Surgery Patients with Controlled Postoperative Blood Glucose. However, as I also previously stated, you must still abstract and submit SCIP-Inf-4 or any case that meets the criteria for any of the SCIP strata. You are going to continue to identify the population size for each of the eight SCIP strata and will still determine the sample size as applicable for each of those strata. The cases and the sample for each of the SCIP strata will then be abstracted for SCIP-Inf-4.

If the case does not have a principal procedure code on Table 5.11 in Appendix A, the case or cases will be excluded from the SCIP-Inf-4 denominator. Otherwise, it will result in a major outcome of B. However, you will still submit those cases to the CMS Clinical Warehouse.

For example, with Strata 1 the population size is zero. No cases would be abstracted and submitted. For Strata 3, which is the hip arthroplasty strata. There are 20 cases that meet the initial patient population criteria for this strata. As the population is 20, at the minimum, you must abstract and submit 17 cases. Seventeen cases will be abstracted for SCIP-Inf-4.

As the cases will not have a principal procedure code of cardiac surgery on Table 5.11, all 17 cases will be excluded from the SCIP-Inf denominator. However, you will continue to submit those 17 cases to the CMS Clinical Warehouse.

Next slide.

For VTE, VTE-1, VTE-2, VTE-3, VTE-5, and VTE-6 will continue to be required by CMS for the IQR program. VTE-4 has been removed from the IQR program and can be submitted voluntarily.

Next slide, please.

For the measure of VTE-6, a new data element, “Reasons for no administration of VTE prophylaxis” has been added. And to provide abstracted clarification, there were revisions made to several of the VTE data elements.

Next slide, please.

For the ICU VTE prophylaxis date and time data elements, the word "initially" was removed from the definition and suggested data collection question. For a reason for “No” for

discontinuation of parenteral therapy, the timeframe were defined. Documentation of a reason for discontinuation must be on the same day or the day before the order for discontinuation. In addition, the timeframe for “reason for no overlap therapy” was also defined. The “reason for no overlap therapy” must be documented on the day of or the day after the VTE diagnostic test.

Next slide, please.

For the data elements, “reason for no VTE prophylaxis hospital admission” and “reason for no VTE prophylaxis ICU admission,” additional clarification was provided as to when you would be able to select “Yes.” Specifically, to select “Yes,” there must be explicit physician/APN/PA documentation that the patient is at low risk for VTE or there must be a contraindication to both mechanical and pharmacological prophylaxis.

For the data element “reason for not initiating IV thrombolytic,” a timeframe was provided. The data element now asks, “Is there documentation on the day of or the day after hospital arrival as a reason for not initiating IV thrombolytic?” Additionally, timeframes were added for the data elements, “VTE confirmed” and “VTE diagnostic test.” These data elements now ask that there was documentation that the patient have a VTE diagnostic test and the VTE was confirmed within four days prior to arrival or any time during the hospitalization.

Next slide, please.

Additionally, a timeframe was added for the data elements, “VTE present on admission.” The element now asks, “Was the VTE diagnosed or suspected on arrival to the day after admission?”

For the data element, “VTE prophylaxis status,” the allowable values were changed to “Yes” or “No.” “Yes, VTE prophylaxis was administered between the admission date and the diagnostic test order date,” or, “No, the VTE prophylaxis was not administered between the admission date and the diagnostic test order date.”

Finally, for Warfarin administration, the data element now asks, “Was Warfarin administered any time after the VTE diagnostic test?”

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Next slide.

For Stroke 2, Stroke 3, Stroke 5, and Stroke 10 they have been removed from the IQR program and can voluntarily be submitted for CMS. Stroke 1, Stroke 4, Stroke 6, and Stroke 8 are still required for the IQR program.

Next slide, please.

Abstraction clarification has been provided to several of the stroke data elements. In addition, a new data element, “reason for extending the initiation of IV thrombolytic,” has been added for Stroke 4.

Next slide.

For the data element, “assessed for rehabilitation services,” clarification was added that the assessment for rehabilitation services must be completed by a qualified provider, which includes a physician, APN, PA, (unintelligible) therapist, neuropsychologist, and OT or PT or a speech and language pathologist.

Clarification was added to the “atrial fibrillation/flutter” data element, that there must be sufficient APN/PA documentation that the patient has a history of any atrial fibrillation or atrial flutter, or a diagnosis or signed ECG tracing of any atrial fibrillation or flutter.

For the data element, “date last known well,” the data collection question asks, “What was the date associated with the time at which the patient was last known to be well or at his or her baseline state of health.” There was also additional abstraction guidance that was added for further clarity and they added the code stroke form template as an additional suggested data source.

Next slide, please.

A timeframe was added to determine the INR value. The data element now asks, “Was there documentation of an INR value greater than or equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy?”

Additional clarification was added to the “last known well” data element. To select “Yes” if both a date and a time last known

well was documented. If the date time is unknown, then you must select “No.”

And, finally, there were exceptions that were added to the data element, “monitoring documentation.” If there is a physician/APN/PA-explicit reason for not using documentation, such as a nomogram or protocol linked to the heparin order, select “Yes.”

Next slide, please.

There were several changes related to the timing for the Stroke 4 algorithm. If the Timing 1, which is the arrival date and time minus the date last known well date and time, is greater than 120 minutes, the case will be excluded from the measure denominator. If the Timing 1 is greater or equal to zero and less or equal to 120 minutes, the case will proceed through the algorithm.

Next slide.

For Timing II,- which is the IV thrombolytic initiation date and time minus the last known well state and time, if the minutes is greater than 270, then the case will (unintelligible) the measure. Otherwise, it does not meet the intent of the measure. If the time is greater than 180 and less or equal to 270 minutes, the case will proceed and check to see that there was a reason for extending the initiation of the IV thrombolytic. If the time is greater or equal to zero and less or equal to 180 minutes, the case will pass the measure. Otherwise it meets the intent of the measure.

Next slide.

For both ED-1 and ED-2, they are both continued to be required for the IQR program.

Next slide, please.

There were minimal changes to the ED data elements. For the decision to admit date and time, these elements no longer require the physician documentation only.

For ED departure time, clarification was added that vital sign or medication documentation that are later than the ED departure time should not be used to abstract this data element.

Next slide, please.

For the IMM measure set, IMM-2 remains a required IQR measure and IMM-1 can continue to be submitted to CMS voluntarily.

Next slide, please.

PC-01 continued to be a required measure for the IQR program. Hospitals will continue to submit the aggregated data through the web-based tool.

Next slide, please.

We have received numerous questions related to why prior uterine surgery is no longer included as an exclusion in the web-based application for the 2014 discharges. For discharges beginning with January 1, 2014, the Joint Commission made revisions to the PC-01 algorithm. Specifically, they moved the prior uterine surgery check from the beginning of the algorithm, to the end of the algorithm, and no longer included it as an exclusion data element. If the patient had a prior uterine surgery as defined by the data element, the case will be in the major population or the denominator only. If the patient did not have a prior uterine surgery, the case will be included in the numerator.

Next slide, please.

Lastly, there were several claims-based measures that were added to the IQR program that have been included in the specifications Manual, including: the Medicare spending per beneficiary or the MSPB measure, coronary artery bypass graft 30-day mortality measure, coronary artery bypass graft 30-day readmission measure, heart failure 30-day payment measure, and pneumonia 30-day payment measure.

Next slide, please.

And now I'd like to introduce Cindy Cullen from Mathematica Policy Research who'll be providing some best practices for submitting questions to the Q&A tool.

Cindy?

**Cindy Cullen:** Thanks, Candace, and good morning, everyone.

Earlier in Candace's presentation she referenced the Q&A tool on *QualityNet*. Today, I'd like to give you some brief tips on how to ask questions through *QualityNet* that will help us help you.

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First, questions relating to abstraction should be coming through the Q&A tool on *QualityNet*. There is no phone support for these questions. The program support contractor does provide telephone assistance, but only for program-related questions.

To access the Q&A tool on *QualityNet*, look on the right hand side of the *QualityNet* homepage and click on the “Hospitals-Inpatient” link. On the next page after that, you'll see a box on the right that says,” Ask a Question.”

When posting your question, it is helpful for our responders to understand the context for your question. Let's look at the example on the slide.

Sometimes we receive questions that only contain the last sentence indicated here, without the context our responders need to spend time identifying the source of your question.

Here's how you can help us improve our response time to you.

When you submit your questions, please include the data element for which you have a question, page number, and especially manual version would be helpful to include. Also, please include a reference-specific note for abstraction or other area for which you need clarification.

We provided the example here for you as a guide. By pointing to the relevant sections, it helps us to identify areas in the manual that may need revisions in future versions. We appreciate your assistance in helping us to improve this documentation.

Candace, back to you.

**Candace Jackson:** Thank you, Cindy, and we appreciate that.

And now I would like to introduce Bethany Wheeler who is the lead HVBP person for the Hospital Value-Based Purchasing Program.

Bethany?

**Bethany Wheeler:** Thank you for that introduction Candace.

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I would like to welcome everyone to our Medicare Spending per Beneficiary edition of the Hospital Value-Based Purchasing Program Improvement Series. In our improvement Series, we are providing a brief educational overview on the calculation of the measure we are spotlighting for the month and having two hospitals that have shown remarkable improvement in the measure speak to their processes and best practices of their improvement within the measure. This month we have guest speakers from McLeod Medical Center Dillon and Memorial Hospital Sweetwater County.

If you have any questions for our two hospitals while they are giving their presentation, please add the hospital name to your question and we will try to answer as many questions as we can at the end of the presentation.

Next slide, please.

A Medicare Spending per Beneficiary or MSPB episode includes all Part A and B claims that occur between the three days prior to an index admission and the 30 days after the hospital's discharge. The claims are included based on the "from" days, which is basically the day which the claim started, or in the case of inpatient claims that occur in the post-discharge period, just based on admission dates.

There are some admissions that are not calculated as index admissions, meaning they cannot start an episode or trigger an episode. Admissions which occur three days prior to within 30 days of the discharge of another index admission, basically those are considered re-admissions, so they are grouped together with the first episode. Also, cases where there are acute transfers where hospitals transfer from one hospital to another in the same day, those are also excluded and are not counted as MSPB episodes. Episodes where the index admission has zero dollar payments are excluded as well. Admissions that have discharges fewer than 30 days prior to the end of the performance period cannot be index admissions. The reason for this is that CMS will not have a complete 30-day window to evaluate the hospital.

Next slide, please.

There are certain types of beneficiaries that are included and others that are excluded from the MSPB measure. Beneficiaries have to be enrolled in Parts A and B from the 90 days prior to the episode through the end of the episode. The

90-day requirement is so that CMS has a complete 90-day history of the patient's health conditions and a number of other variables that are used in the risk adjustment of this measure. Additionally, the beneficiary must be admitted to a subsection (d) hospital.

Beneficiaries are excluded if they are enrolled in Medicare Advantage at any point during the time period; if Medicare is their secondary provider; if they died during the episode, meaning if they die either during the admission or during the post-discharge period; or if they're covered by the Railroad Retirement Board, the individuals will be excluded from the MSPB measurement.

Next slide, please.

The standardization adjusts claims for geographic payment differences, hospital-specific rates, payments for disproportionate share hospitals, and indirect medical education payments. The goal of standardization is that CMS can compare hospitals in one area to hospitals in another area based on utilization rather than price differentials. The general concept is that CMS wants to focus on the differences in utilization by hospitals during the admission and in the post-discharge period across all providers and normalize for the spending of these different payment policies. In order to standardize the payments, CMS calculates an overall spending level for the episode, which is the sum of the standardized episode spending for all Part A and B claims during the time period. The standardized spending amounts are standardized based on Medicare payments, patient deductibles, and co-insurance.

Next slide, please.

On this slide, we have listed the risk adjustments that are made to account for the expected episode spending. The point of this risk adjustment model is to counter variation in patient case mix across hospitals. Case mix can be measured by a number of factors such as age and severity of illness. To measure risk adjustment, CMS uses a linear regression model, also known as ordinary least squares or OLS, and this regression estimates the relationship between all the risk adjustment variables and the standardized episode spending.

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Another step that CMS takes after the calculation of predicted values from the regression, is resetting or winsorizing the expected cost for some extremely low-cost episodes.

Next slide, please.

The MSPB amount for each hospital is calculated as the ratio of the average standardized episode spending divided by the average expected episode spending, multiplied by the average episode spending across all hospitals.

Next slide, please.

The MSPB measure for each hospital is calculated as the ratio of the MSPB amount for the hospital divided by the median MSPB amount across all hospitals. The median MSPB amount is calculated as a weighted median, where CMS gives more weight to scores that have more episodes. This ratio is the value that is used in comparison to all hospitals in the Hospital Value-Based Purchasing Program.

Next slide, please.

Hospitals may be scored on improvement and achievement for all measures within the Hospital VBP Program. Hospitals may earn a maximum of nine improvement points and 10 achievement points, with the greater of the two scores being used as the measure score. On the slide, I have an example of an improvement point calculation that would have been used for the fiscal year 2015 Program. The result of this example is eight improvement points.

Next slide, please.

The next example is scoring of achievement points. A hospital that has a ratio that is equal to or better than the benchmark which is the mean of the top decile of all hospitals during the performance period will receive 10 achievement points. A hospital that has an MSPB ratio that is less than the achievement threshold which is the median or 50$^{th}$ percentile of all hospitals will receive zero achievement points. Hospitals that score between the two performance standards of the benchmark and the achievement threshold will receive one to 10 points. In this example, the hospital had a ratio that was between the achievement threshold and the benchmark and received eight achievement points.

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The measure score for MSPB is calculated by identifying the greater of achievement or improvement points. In our example, the hospital earned eight points for both improvement and achievement, so eight points would be awarded for a measure score. Had the hospital received 10 achievement points and zero improvement points, 10 points would be awarded. In FY 2015, the “Efficiency” domain, which contains the MSPB measure, was weighted at 20 percent of the Total Performance Score. A hospital that scored the highest score of 10, would have 20 points added to their Total Performance Score for FY 2015 using the original weightings.

Next slide, please.

Our first guest hospital exhibited great amounts of improvement in the MSPB measure. The graphic on the screen displays how much they improved based on the distribution of all other hospitals in the nation. The hospital had a baseline period ratio recorded from May through December of 2011 of 0.987830 which was worse than the median or 50$^{th}$ percentile of all hospitals. By the recording of the performance period of May to December 2013, the hospital improved their ratio to 0.846048, almost reaching the benchmark or the mean of the top decile. McLeod Medical Center Dillon received eight improvement points, eight achievement points, and a total of eight for their measure score that helped the hospital reach a Total Performance Score of 66.7!

Next slide, please.

Our next hospital, Memorial Hospital Sweetwater County, also showed remarkable improvement. They started their journey with a baseline period ratio of 1.017906 and improved to a performance period ratio of 0.853161. They also received eight improvement points, eight achievement points, and eight points for their measure score which helped the hospital reach a Total Performance Score of 53.9!

Next slide.

Before we introduce our guest speakers, we would like to take the opportunity to give everyone resources for more information regarding the MSPB measure. The first bullet is a link for detailed methodology and calculation examples for MSPB. I

provided a very brief overview, but for more information, please check out this resource.

If you have any questions regarding the MSPB measure, please send them to CMSMSPBMeasure@acumenllc.com, and questions regarding the Hospital VBP Program can be sent to the VIQR Support Contractor.

Next slide, please.

I would like to introduce our first guest speaker, Donna Isgett. Donna Isgett, MSN, is Senior Vice President of Corporate Quality and Safety at McLeod Health in Florence, South Carolina. Founded in 1906, McLeod Health operates four non-profit hospitals and serves as the regions tertiary care facility for a population nearing one million people.

A native of Atlanta, Georgia, Donna received her Bachelor of Science Degree in Nursing from Georgia State University and her Master's Degree in Nursing from the Medical University of South Carolina in Charleston. She spent the majority of her clinical career as an emergency flight nurse.

Donna joined the McLeod team in 1997 and is currently responsible for the corporate oversight of the Divisions of Clinical Effectiveness, Service Excellence, Operational Effectiveness, Risk Management, Epidemiology, and Case Management. Donna is also Co-Chair of the McLeod Health Quality Operations Committee and a member of the McLeod Regional Medical Center Community Board.

With that Donna, the floor is yours. Thank you.

**Donna Isgett:** Thank you. Good morning. That was an embarrassing introduction. I'm just a normal nurse working in a great healthcare system here in Florence, South Carolina.

If we can move to the next slide, please.

And we really are the cornerstone of the medical care here in South Carolina.

Next slide, please.

And this shows you -- sort of for those that aren't familiar with the state -- what I mean by that cornerstone. Literally our state is divided into four regions and we serve a 15-county area. We're the primary tertiary care facility in this 15-county area.

You notice Florence there in the middle of this region and then Dillon with a star on it, because today I'm going to speak primarily about our hospital that exists in that Dillon County, the sole provider in that county actually.

Next slide.

First, understand our system.

In our system we actually have five physical hospital buildings that you see listed here. The primary tertiary care facility, that's McLeod Regional here in Florence with 493 beds. The institution we're going to talk primarily about today, our Dillon facility, with 79 beds. We have facilities in Darlington, Loris, at the Beach, [and] at Little River, it's Seacoast. We also have inpatient behavioral health beds on our Darlington campus, as well as an inpatient hospice house. [I'll} give you a few more demographics because I think it's important that you understand who we actually are as an entire healthcare system.

Next slide, please.

This really focuses on our Dillon campus. As I mentioned before, it's the sole provider in Dillon County. And you will notice on this campus, even though it was founded and built back in the 70s, we've had a lot of renovation and improvement, including that new ER that you see sticking out front.

Next slide, please.

So, [I'll] tell about the McLeod Medical Center in Dillon.

Dillon is a county of about 32,000 people. As I mentioned, we have 79 inpatient beds there with a very, very busy ER. We see about 28,000 emergency department visits there.

This facility is located right on Interstate I-95 that runs from New York down to Miami. As a matter of fact, we're the halfway point between New York to Miami. And to any of you that have ever traveled that road, we're just south of the border. That is Dillon when you see those signs on 95.

They have a lot of active physicians, many in consulting roles for that campus, and a few more of the demographics, noting that we have a payer mix here, primarily governmental, but also

a very high self-pay population. I put the positive operating margin on there because with that payer mix, that it's hard to net in a small hospital like this, but it has always run in the block. And I think a lot of that has to do with the reason I'm speaking with you today.

Next slide, please.

As already mentioned, we've been recognized by numerous quality organizations, but I particularly want to talk about that in Joint Commission for our Dillon campus, they've been a top performer hospital and have maintained the "A" rating in the Leapfrog Group. So, all of the quality infrastructure I'm going to talk about takes place across all of our organizations, but it's been very productive here on our Dillon campus.

Next slide, please.

You just heard about our Medicare spending per beneficiary and saw those numbers, but I had reiterated I'm here for you to see what a difference it's made in the actual spending per beneficiary in our community.

Next slide, please.

So how do we think we've done that?

We really took to heart not just what the American Hospital Association recognized in their Quest for Quality Award, the criteria of crossing the quality chasm, but it has been the guiding principles for us at McLeod Health to look at those six aims for improvement and to develop a strong infrastructure around netting those actual aims.

Next slide.

In those, it's about delivering according to crossing the quality chasm: safe, effective, efficient, timely, equitable, and patient-centered care. And those six things have really driven our programs for quality improvement within the McLeod Health System.

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We then divided that – or created that into what we call our Quality Pyramid: first, Do No Harm -- Quality of Safety; second, Heal Me -- Quality of Science; and, third, Be Nice to Me -- Quality of Service. Really making sure that we look at

everything through the lens of quality safety, science, and service, but note that it's built on this foundation of evidence-based care.

We believe strongly that physicians should lead the work in the clinical arenas, at least; that executives should not only be present, but be actively engaged in that work; and it all be centered around a culture that is just making sure that you can net the quality of safety, quality of science, and quality of service.

Next slide, please.

So how have we taken that strategy and put legs on it, as I say. How did we make that into real tangible things?

It really takes a quality infrastructure and a quality focus. I will tell you, in our Board of Trustees meeting -- I had one last night from McLeod Regional Medical Center and McLeod Health will be on Monday -- we always start those meetings with our quality report. Usually physicians standing up talking about true quality improvement as well as a full dashboard of our quality improvement efforts so that all the boards on each campus can keep up with what's going on and the McLeod Health Board can as a whole. That's part of that quality and safety strategy.

But how we net those results are in three, not compartmentalized, buckets, but in three frameworks; one of clinical effectiveness, one of operational effectiveness or LEAN, and one in service excellence.

Next slide.

In our clinical effectiveness work, we really work on those two focuses of safe and effective. Here we use physician led, evidence based, and data driven teams to look for opportunities for improvement. And then, to actually drive those opportunities through, we might ask what does that have to do with cost when it's taken away out of the healthcare delivery system when the waste isn't netting value for the patient. So, really using those physician-led, evidence-based, data-driven teams to do that.

And let me show you what I mean.

Next slide, please.

## Support Contractor

Here are some sample data just to give you some idea of what we call our opportunity assessment. We run an opportunity assessment every six months on every one of our campuses at McLeod Health, and particularly, this is something that we did on our Dillon campus, and looked at the opportunities to take waste out of the system. Waste for us means waste in cost, waste in length of stay, opportunities to save lives, opportunities to save complications, and save readmissions. So we run that data. We use the Premier Data Source – Premier Quality Advisor Tool – for us -- but we run that data through those five filters and then create a prioritization matrix to figure out where it is we need to go work in particular areas, and that really drives the said data-driven parts, so then the physicians can engage and do the evidence-based delivery when we figure out where our opportunities are to improve.

Next slide, please.

Some of the other things that we've done – We've always - actually not always, but since 1998 we have had this very rigid structure of opportunity assessment using data, physicians to drop their work. What's happened recently though is that we moved outside of the hospital walls. So before we might work on something like heart failure, but we would worry about the care within the walls of an institution. Now we've started to reach outside of the hospital walls on things like heart failure, all the chronic diseases, and say, "How do we net all of these together? How do we make these knitting happen so that we're really improving the care across the continuum?"

Multiple things you see listed here are heart failure, stay at home –home to stay program. We work with our QIO on implementing some of the best practice evidence-based things like "teach back" and multidisciplinary rounds and meetings, and high risk assessment tools for readmission. Some of our chronic care management – We actually have a grant from the Duke Endowment to take social workers out to do home visits, looking at transportation assistance, and using nurses to reconcile the medications at discharge, and then call and follow up and make sure those prescriptions were done.

Healthy outcomes program is we're reaching outside to eliminate unnecessary emergency room utilization and try to get to the five Whys – Why are they using the emergency department? Were they not able to get their medications? What are the drivers that we could do something about? We've also negotiated in our community to bring in a federally qualified

health clinic. We did not have a federally qualified health clinic within the Dillon community, nor did we have a free medical clinic, and we worked in conjunction with both to help to subsidize at least the capital expenditure for a federally qualified health clinic, and also to open a free medical clinic trying to continue that continuum – kind of a double statement there, but continue the continuum that exist for those hospitalized patients that then are going in and out of the community.

The final thing that we added that I didn't get on this slide was, we moved our quality infrastructure out into the physician organization, so our McLeod Physician Associates. I actually have an associate vice president for quality and safety within those physician organizations, and we are using the same sort of data mining to look for opportunities in how those physicians are managing chronic diseases.

Next slide, please.

Much of this is work in and outside the hospital. As we start to then look at the details, look what happened to the readmission rates.

So, you see pretty dramatic reduction to the readmission rates in heart failure, heart attack, pneumonia, and even in COPD. So we really believe that this, from that clinical effectiveness work that was inside the hospital as well as out, is probably one of the key drivers of why we've seen our cost reduction in the Dillon work. This is actually Dillon data that you're looking at.

Next slide, please.

What are some other things that we think have made a difference?

Certainly reducing the number of hospitalizations and need for those hospitalizations, or reducing readmissions had a great impact, but some of the other things that really made a difference were looking – was looking inside of our hospitals in an operational effectiveness way, looking at efficient and timeliness of care, using LEAN principles and using waste, developing standard work, and engaging the people closest to the work to actually improve the work.

Next slide, please.

## Support Contractor

Same principle, we use data. We use data to figure out where opportunities are to improve. I know this is very small print on the slide, but what I want you to understand is using comparative data to look at how many man-hours per procedure are we using and where, all the way over there in that right hand column, are there opportunities to save dollars, and how we're staffing or how we're using particular areas, the number of OR cases, what our security use is. You see Item Number 3 is food and nutrition cost per tray. And then we're going to take you through how we actually did those improvements.

Next slide, please.

So we pulled together a – actually employee-led team to work on nutrition services because our cost per tray in nutrition services at the very beginning of this work was (right in) $11.13. We wanted to reduce that. That was higher than the benchmark data that you looked at on the previous slide. We wanted to reduce that. We also wanted to improve the efficiency for the patient and what our turnaround time was for ordering a new tray until we could get it to the patient's bedside, and then the patient satisfaction saying - (percent) saying, “Excellent, yes, this food was excellent.”

That team pulled together in lean environment what we call operational effectiveness. Doing true rapid improvement events, we're in fact able to – we saw dramatic improvements in cost. Look at the tray cost going from $11.13 to $6.29. That really just reducing [didn’t reduce] the quality of the food we provided. As a matter of fact it was better. It was taking the waste in the trays out of the system. There were so many pounds. We were making trays and the patients (unintelligible) – Those sorts of measures that were really waste that didn't help at all. Really taking the core cost out of the care that we're delivering, and that being in nutrition.

We also did some things in our Emergency Department. Classic, also operational, effectiveness worked; looking at length of stay and other measures in value-based purchasing.

Next slide, please.

And our third bucket of work is really on the service excellence side. But being very organized – to have service standards, the things we say that mother should have taught you but maybe she didn't, really clear standards of the expectations of any

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McLeod Health employee – the top of that pyramid of service excellence are quality of service.

Next slide, please.

Using other ideas not just the service standards that you see here in the [middle] of this pyramid, but building an infrastructure or culture around that of accountability, of leadership, of shared vision, using some of the tools and skills that we know are important like bedside shift report, making purposeful rounding – both purposeful leader rounding, the leaders checking in on the patient, but also comfort rounds. Those were some of the tools and skills that we developed, and then really empowering our employees to have an authentic personal relationship to really connect with some empathy training and other things within our service excellence strategy which knits to our quality of service.

Next slide.

And here are some of the results. Remember I said our Board of Trustees looks at big system results all the time? And how you read this graph – this is a graph that they look at year over year. Actually, they look at it quarter over quarter. How you read this is in the blue, and this is for all of McLeod Health. This is not just Dillon's performance. Dillon's performance even looks better than this. But if you're in the blue we're at the mean of the top decile. We have measures in one of those eight domains at the mean of the top decile. In the orange it's at the 75th decile – 75th percentile to the mean of the top decile, and then the green is at the 50th percentile better.

Notice in this last year we have no red. Actually, the red the year before is when we brought on two new hospitals to our system that really had opportunities to improve.

So using these sorts of visuals, not only in service, but in mortality rate and readmission rate – that you saw complication rates – really using those visuals to monitor sales at a very high level.

Next slide.

I hope in this brief conversation that you've been able to understand just exactly what the infrastructure is that we're using in each one of our campuses. So all of those five hospital – inpatient hospital campuses uses this exact infrastructure,

these exact guiding principles, as the associate vice president of each one of those campuses works to improve quality overall so they can make a difference in our patients.

So we have been focused on that Medicare spending per beneficiary, but we've really been focused on all of the metrics in the value-based purchasing program.

Last slide.

We really are devoted to medical excellence. We have chosen, as a healthcare system at McLeod Health, to differentiate ourselves on the quality of care we've provided, and I hope I've given you just a glimpse into how we believe we have netted those results that have made such a difference for our region.

Thank you.

**Bethany Wheeler:** Thank you, Donna, for your wonderful presentation.

And just a reminder to all of our participants, if you have a question for Donna regarding McLeod Medical Center, please submit those questions and either type in Donna or McLeod Medical Center so we can get those questions answered with the appropriate person.

And if you would – if you have a question for our next speaker, please either type in Amanda or Memorial Hospital Sweetwater County.

So, I would now like to introduce our next guest speaker, Amanda Molski. Amanda Molski joins us from Rock Springs, Wyoming. Amanda is an RN with experience in the intensive care unit, and for the past years has been Quality Coordinator at Memorial Hospital of Sweetwater County. She's also a clinical instructor for the University of Wyoming Nursing Program.

Amanda is originally from Michigan where she received her undergraduate degree in biology from Michigan State University followed by her BSN from the University of Wyoming and her completion of her master's Degree in Nursing from the University of Cincinnati.

Her role in quality and performance improvement initiatives at Memorial Hospital of Sweetwater County, while challenging, has been very rewarding thus far.

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Amanda, you can now take the floor.

**Amanda Molski:** Thank you.

This is Amanda Molski. Hello, everyone. I am the Quality Coordinator at Memorial Hospital of Sweetwater County in Rock Springs, Wyoming.

We have been given the opportunity to share with you some of the changes that we have made in our organization that are correlated to our Medicare spending per beneficiary ratio, as well as success with the overall value-based purchasing program.

Next slide.

A little bit about Memorial Hospital of Sweetwater County. We are a 99 bed not-for-profit community hospital. We're located in scenic Southwest Wyoming, serving the region of the state. I say scenic Wyoming. I don't know if any of you have been to Wyoming, but if you have, you know there's not a whole lot surrounding some of the small towns here, but vast amounts of unpopulated by human, heavily populated by animal, very scenic land.

Our organization serves the region with acute care services and also a clinic, with the next largest hospital offering additional care that we cannot provide due to resources nearly 200 miles away. Because of our location and minimal surrounding resources, we do have to strive for efficient and effective care for our community on an effort to utilize resources to the best of our abilities to ensure patients are given high quality care. And then, in winter months, it's not always possible, and the best option [is] for people to travel several hundred miles away to get those services.

Next slide, please.

As mentioned previously, Medicare spending per beneficiary, defined as part of the hospital value-based purchasing program, assesses Medicare Part A and Part B payments for services spanning from three days before inpatient admission through 30 days after their discharge.

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As you can see, MHSC's Medicare spending per beneficiary ratio showed a shift forward and success from our baseline to our performance period for the fiscal year 2015 value-based purchasing program. We moved from a ratio of approximately 1.02 and decreased that to approximately 0.85.

During our baseline period in 2011, Medicare was spending more than [the] national median on patients that were seen in our facility as compared to our 2013 values, which is the goal of value-based purchasing program of providing higher quality, more efficient and effective care at lower cost for our patients.

So many of you might be asking, well how [did] we get there? And one thing I hate to say is, there's not one certain thing that we did that may have contributed to this success, but more so, a ranging compilation of several different things that we initiated throughout 2012 and 2013 that, in conjunction with each other, may have led to our organization seeing positive results. We do not necessarily focus solely on this Medicare spending per beneficiary ratio alone, but, again, made changes in several other areas in the measures that intern could be correlated with this measure.

Next slide please.

In 2012 I would say we somewhat lacked full understanding of the value-based purchasing program and what all the elements entailed. We were kind of lost on where to pick up and start. So, at end of 2012 we figured, we can't fix what has already happened in the past and play catchup, so let's look forward and prepare for the upcoming year, to the things we can work towards for 2013 which would be reflected in the Fiscal Year 2015 value-based purchasing dimension. We looked at areas and (missed) 2015 dimensions so we could actively make changes to improve on in order to see success.

One of our things that we mainly focused on was the clinical process of care measures. Our thinking was that if we could improve one slice of this pie, we could impact some of the other areas, for example, working to improve surgical SCIP measures. We can improve our Foley catheter removal rates within – once in the SCIP measure we can in turn impact infection rates, which is a composite in the Outcome Measures. And, again, [increasing] our efficiency in the Medicare spending per beneficiary by again, preventing infection, reducing additional and unnecessary treatment and services. Same with AMI, for example. So, improving these measures in the Clinical

Process of Care could impact and alter other outcome measures and other pieces of pie here.

Similarly, all of the other Clinical Process of Care Measures could impact this. So, [as] I said, we just started with a focus on one little slice of this pie.

Next slide, please.

By the end of 2012, once we had a little better understanding of the value-based purchasing program, we started by sharing our information and knowledge with all of our employees, senior leaders, and our board. This included going to medical staff meetings and sharing the knowledge with our providers, along with preventative measures; giving specific information on where our focus was – for us it was the clinical process of care; and how we are going to start improving some of these things. We did the same at clinical staff meetings, board meetings, [and] performance improvement committee meetings. And from there each department branched out and devised areas they wanted to work on in addition to this, such as medication reconciliation, compliance with documentation, timeout appropriateness, et cetera. We started getting information out there, making more people aware of what we were working towards.

Next slide, please.

We started small work teams to look at each of the measures within the Clinical Process of Care, monitor[ing] the data. When we came across opportunities for improvement from abstraction of these measures, we'd immediately inform providers and other care providers involved with the patient's care, explaining the measures, what we are looking for, along with reasoning behind the measures, and let them know of any documentation that might be missing within the charts. And this sparked our concurrent rounding that we currently do on patients that we find highly likely to fall in some of the certain measure categories. Again, making sure all elements of the measure were met and documented appropriately – why the patient was still in the hospital.

Information of missing data was communicated to providers and those on the care team at our interdisciplinary meetings. Our interdisciplinary meetings occur daily. It includes several members of the care team, including: the providers, case managers, transition nurse, quality nutrition, infection control,

physical/ occupational therapist, pharmacy, et cetera. We had been doing this for a few years. We can say back in 2011, but one of the major changes that we made in 2013 was the inclusion of the provider in these care meetings. This helped immensely with communication and also allowed an environment where we are all able to discuss care about the patient.

Included in this was, of course, core measure information and the elements we still needed, which then spark further conversation about maybe what tasks were necessary, if they were truly needed, discharge planning processes, looking at things we could do so the patient would do well after discharge, including large areas or risk for infection, and focused on prevention mainly, taking into account the “what if”, discussing ways to prevent those things as a team with the providers.

We also started bedside shift reports, putting the patient in the middle of the report. Again, reducing waste through miscommunication or misunderstanding of patient's wishes.

[We] also work very closely with our I.T. department, ensuring appropriate areas within our medical record were available to reflect interventions we were giving, as well as overlapping a lot of our work with that of the meaningful use requirements.

Looking back, although we were focusing on again, on one piece of that pie, the Clinical Process of Care, -- we were impacting several other areas of the pie which we can see correlated with some of our Medicare spending per beneficiary success. Working to prevent harm, prevent infection, give evidence-based care and appropriate treatment, and just to prevent unnecessary spending for needed services down the line once the patient was discharged.

Next slide, please.

Throughout both 2012 and 2013, our infection preventionist worked diligently to set up evidence-based care bundles. We got new oral care kits for our ventilator patients. Again, [we] worked with our I.T. department to ensure appropriate areas for documentation within our electronic medical record. We started asking a lot of questions about Foley catheters, set up certain criteria for placement of our catheters. And at first we did not see much change, but then we really started asking the questions, which is definitely key, “Why do they have catheters? Do they meet the criteria? When can we take them

out? Do we really need it? Did you document it?" And soon after that is when we started seeing a large decreasing trend in our Foley catheter days. Definitely, you know, impacting less opportunities for harm and infection for our patients, in turn improving quality metrics of our infection rate, Clinical Process of Care, outcomes, and, again, correlated with our Medicare spending per beneficiary, all working towards prevention. And, again, focusing on one area of that pie, but, again, impacting all of the areas.

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Further, we started off a cardiac and pulmonary rehabilitation unit. Now having the ability to care for our patients post AMI. Again, all in effort to prevent further complications from occurring.

In addition, [we] started a transition program in which we have a transition nurse that sees high-risk for readmission patients in the hospital acute care setting, follows them into the home setting, and then works with them post 30 days after discharge. Our transition program, again, focuses on prevention and education mainly, working with patients to reconcile and understand medication treatment, assist with utilization of community resources and support, setting up follow-up appointments, ensuring their needs, as well as patient – as well as family and caregiver needs, making sure all those needs are met in the home setting, and that they have access to appropriate resources during that 30 days after discharge. All of this in an effort to prevent future complications. Again, impacting other areas of the value-based purchasing pie such as the Medicare spending per beneficiary, as we're working on reducing additional and unnecessary services of care through a focus on prevention.

In 2013 we also did see a large decrease in our readmission rates correlated with the start of our transition program. Similarly, our Medicare spending per beneficiary report showed less being spent on services in the 30 days after discharge as compared to national median.

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Since MHSC is located in a rural area, we do have limited resources. That's why it's necessary to find ways to effectively and efficiently provide care to our patients, since we had minimal resources to do so. Collaboration with community

entities begins mainly with long term care facilities, clinics in the community, home health and hospice. We work together with each other to find ways to manage patients and treatment in their home settings as much as possible. Again, on prevention and making sure we were utilizing resources in the community effectively. For example, our hospital ED and our long term care facility would discuss the patient condition and reasons for transfer to the acute care setting prior to that transfer being made. If treatments could be managed in a long term care setting, the patient would have – would not have to be admitted, again, reducing unnecessary admission and healthcare cost burden to the patient and family. But it was mainly just a matter of effective communication and use of our community resources to their potential to decrease some of those unnecessary admissions.

Being a rural state and a regional care – acute care facility, we also have numerous people traveling several miles to get to our facility for appropriate and needed care. To reduce this burden and chance for additional unnecessary services, we worked with organizations outside of our own community but within the state. This included coordinating care with long term acute care facilities, setting of home health, and use of needed resources in the patient's own home town to make sure that patients have everything they needed before being discharged from our facility, again, all preventing additional services the patient may need down the road due to lack of adequate planning and coordination of care.

Next slide.

One large hurdle that we had faced in what was a major change in 2013 as compared to our 2011, was provider engagement. Once we started getting information out there, consistently talking about quality and value-based purchasing, bringing the data to medical staff meetings, routinely asking for input, we saw much more engagement from our providers.

We also had a change in our providers. Our county uses a hospitalist system. Throughout 2012 and 2013 we had several different providers rotating throughout our facility, some for only two days and then a new provider coming in, [patients] rarely seeing the same faces consistently. This made it very hard on the coordination of patient care, especially with information being passed along, adequate history, [and] diagnostic test information. Beginning in 2013, we transitioned to a new provider group in which we saw more consistency, three

providers rotating throughout our facility. And this has helped immensely in coordination of care and improved communication, definitely among our providers and for our patients.

We also added several specialty providers to our organization in 2013, and this is assisted. And again, additional knowledge of specialty areas that we were not able to offer in previous years, leading to improved use of resources. For example, we now have more consistent ventilator management, [and] more timely end of life decision [making].

We added education to providers between observation and patient statuses, as providers gave feedback on areas that they needed more assistance with in regards to documentation and knowledge about our value-based purchasing program. We have more open communication between our providers and our employees, with providers more aware of our quality initiatives and focus. And our providers are also participating in provider-specific education to assist with accurate documentation, as well as outlining clear expectations of quality goals and performance along with data transparency.

All of these efforts, again, provider engagement, have also been heavily supported by our organization, CEO and senior leadership team.

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And so, while we have made several strides and improvements in our overall quality and safety within our organization as reflected on our value-based purchasing and Medicare spending per beneficiary report, we do still have a long road ahead of us. We have just scratched the surface.

So far in 2014 we had our first annual quality and safety retreat where we set new goals and focus areas for the year. And we continue to evaluate the value-based purchasing program and consistently look for areas of where we can improve, taking one piece of that pie at a time. One of the biggest things we've learned from this so far has been seeing how one little slice of that pie can impact several other areas. And we've seen how everything is interrelated and prevention is key to improving outcomes for our patients and the well-being of our community.

And so, that's all I have.

**Bethany Wheeler:** Thank you very much for your time.

**Deb Price:** Hello, again. We now have an online CE certificate process. There are two methods for receiving your CE.

Number 1, if you registered for this webinar, a survey will automatically pop up at the end of the presentation.

And secondly, to receive your CEs, if you're attending the webinar as a group, please forward the survey to the other attendees. In order to receive your CE certificate, you will need to complete the survey, and at the end of the survey, click "Done," which takes you to a page where you have to indicate whether you're a new user or an existing user. If you have listened to any of our other events and have received certificates, you are an existing user.

If, however, an automatic reply does not go to your email, please open the secure wall that you have on your email. You can see on the slide ahead – the slide in front of you, the wall would be LMC, that's for Learning Management Center, lmc@hsag.com. Please have your I.T. team open your wall to that domain. Once you have registered into the Learning Management Center, you will not have to register again for any of our exams.

And now I'd like to open the floor for our subject matter experts to review questions that came in during the event.

We're going to start with Candace. Candace, can you share some questions with us?

**Candace Jackson:** Thank you Debbie. Yes, I do have a few questions that I can share.

Question 1: "Can you recap what chart-abstracted measures are required for the IQR program?"

And I wanted to just clarify today's presentation focused on submitting the chart-abstracted measures only and did not get into the integration of chart-abstracted versus the submission of the voluntary ECQMs.

The required chart-abstracted measures for IQR includes AMI-7a, SCIP-Inf-4, VTE-1, VTE-2, VTE-3, VTE-5, and VTE-6, Stroke 1, Stroke 4, Stroke 6, Stroke 6, and Stroke 8, ED-1 and ED-2, IMM-2, and PC-1.

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Second question: “If our hospital does not do cardiac surgery, are we required to submit SCIP-Inf-4?”

And yes, that is correct. You will continue to submit the population sample sizes for each of the eight SCIP strata. And then, if there is any applicable cases in those eight strata, the cases in the sample for each of the SCIP strata will then be abstracted and submitted.

Next question: “Is AMI-7a an optional chart-abstracted or electronic measure?”

And the response is, AMI-7a is required for the IQR program. The measure can be submitted as either chart-abstracted or as an electronic clinical quality measure, or ECQM to meet the IQR submission requirements.

The next question that I saw was, “What is the reason for making the measures voluntary?”

And the measures that we're – we removed from the IQR program and made voluntary in the manual is due to them being deemed as crossed-out. So, as such, there is no more room for improvement for those measures.

“Will CMS continue to support CART?”

And that is correct. Yes, CMS will continue to support the CART tool.

Next question: “Is there any benefit for submitting the voluntary measures?”

And the benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients, and to continue to identify areas of quality improvement.

And my last question, which again I saw quite frequently was, “How long will the voluntary measures be accepted by CMS?”

And all measures that are now considered voluntary that are on the Specifications Manual, except for IMM-1, will be removed from the Specifications Manual beginning with October 1, 2015 discharges. At that time they will not be able to be submitted voluntarily to CMS.

And that is all the questions that I have.

Bethany, do you have any questions?

**Bethany Wheeler:** I do. Thank you, Candace.

The first question that we have is for our first half of the guest speaker, Donna. And the question is, “How many full-time employees do you have to support this system?”

**Donna Isgett:** That's a difficult question based on which hospitals we have in how we're doing the work.

In the Dillon – on the Dillon campus those are operational effectiveness work and our service excellence work are staffed from our corporate office, so we dispatch them based on the biggest needs across the system. Although traditionally they would have one LEAN facilitator that works primarily with the Dillon campus a year and one service excellence FTE that would work there, and then they keep their own clinical improvement person that resides on their campus all the time, as well as infection control. So, on that campus in real numbers, they have three to four FTEs that are doing nothing but improvement in clinical operation and service, as well as the associate vice president on that campus, Jun Urban, who oversees the entire program.

**Bethany Wheeler:** Great. Thank you.

Amanda, you also received the same question. “How many full-time employees do you have to support these measures?”

**Amanda Molski:** I guess, overall hospital facility, we have roughly about 400 employees in our organization. To support some of our improvement efforts and let's say quality specifically, we have myself, Quality Coordinator, and one other full-time quality analyst, as well as a part-time quality analyst, and then Safety and Compliance Officer that we work very closely with for our quality and safety initiative, so about roughly four, you know, total.

**Bethany Wheeler:** Great. Thank you.

The next question is for Donna. Please explain “refraining from providing services to those is not likely to benefit.”

**Donna Isgett:** Actually it's refraining from – I think I put this in the chat – It's refraining from providing services not from the – to the individual person, but refraining from providing wasteful

services. One of the things I use as an example was in orthopedics. We were using a passive continuous motion machine that physicians have gotten [in] the habit of using, but when we really went to the evidence base, we could [not] find their justification for that. We encouraged them to do a pilot of not using it because we were about to have to purchase more. They're about $250,000 [each]. They didn't find a difference in the outcomes with their patient, so they stopped providing that particular part of their care delivery. So, it's really critiquing and going to the evidence to make sure that everything we're doing is evidence-based and taking out the things that are not.

Now, in the emergency room setting, there is some ways of services, so that might – maybe where that was picked up is they're coming to the emergency department when in fact they would be better served if they would go to another facility, such as the federally qualified health clinic that could be a primary medical home, and so is an episodic care provider. And so, really connecting with those patients to make sure they're in the right setting getting the right care. Instead of episodic care, they're getting more chronic disease management.

**Bethany Wheeler:** Great. Thank you for that example.

The next question, I believe, is for you as well. "How were the operational effective measures identified? Is there a longer list of measures?"

**Donna Isgett:** There's a much longer list. It's really how we identify the opportunities to improve operations, and we also use Premier Product (unintelligible). There are multiple products, I'm not trying to just promote theirs, but [we] use that product, and we looked at where the opportunities operationally to improve. Are we working too many man hours per surgery? Are we using too many man hours per procedure or are our supply costs too high per procedure? And that gives us directional data – no different than the clinical data – to go ask why, to go get deeper into that particular area, just like we did in nutrition services, to figure out where is the waste and where are things that we might go work on. Then the individual teams, after they've done those rapid improvement work in that particular area, decide which metrics they would continue to monitor to make sure they maintain success.

The real secret to all of these is, use data to tell you where to go work. Don't just go, "(Hmm), I think (choose this)." Use data.

And there is enough of that out there now to figure out and prioritize your opportunities for improvement.

**Bethany Wheeler:** Thank you, Donna.

Our next question is for Amanda. “How did you get the providers to come and participate in the interdisciplinary meeting? Did you have one meeting with all providers or more than of the one-on-one with the providers?”

**Amanda Molski:** Our interdisciplinary meetings currently are set up more – I guess it's a daily process. We have all of our care team there, and then we usually just have either our main hospitalist provider on that joins us, or an addition to that we sometimes have some of our specialty providers that will pop in the room and join us, as well.

As far as getting them involved, it just became kind of a – say, more of a culture thing as we move forward with our quality initiatives. Mainly just saying, "You know, this is what time we're meeting. We really need you here," you know, instead of them – some of those things that you have with miscommunication when all those people are not in the same room. Pretty much it came down to, you know, we can have ten people asking you the same question ten times throughout the day or we can all meet at one time and, you know, kind of get through everything all at once.

**Bethany Wheeler:** Thank you.

The next question is, I think it could go to both of you, “Is it recommended that we continue to do concurrent rounding on the retired measures starting in January, such as the pneumonia and heart failure measures, in order to prevent the 30-day readmission?”

I think, Amanda, we can start with you.

**Amanda Molski:** I guess I don't know truly how to answer that. I think it's kind of up to you and where you stand in your improvement efforts at your facility. I don't know that it can hurt, you know, to do kind of those concurrent roundings. Well, it's not a required measure anymore, but it does impact readmission rates and what not. For our facility, though, we do have our transition program which focuses on a lot of those things which they are able to pick up, kind of the concurrent patients, and take over that. So, I don't know if necessarily concurrent abstraction or rounding to

see if certain measures are met in that sense, more so than focusing on education and discharge planning and those things for those types of patients.

**Bethany Wheeler:** Thank you.

Donna, do you have any additional input for that question?

**Donna Isgett:** No. We're using [a] very similar process.

**Bethany Wheeler:** Okay, thank you.

The next question is, “Curious if there exists any way to monitor MSPB more frequently than is probably reported.”

And to expand on this question, the MSPB measure is reported annually on Hospital Compare and then also annually through the hospital value-based purchasing program.

“So, do either your two hospitals have a system to have the MSPB data updated more frequently at your hospital?”

**Amanda Molski:** This is Amanda from Memorial Hospital, and currently, no. Our facility does not have a system set up to monitor this more frequently, as of right now.

**Bethany Wheeler:** Thank you.

Donna?

**Donna Isgett:** And this is Donna. Not that we can monitor it more frequently, but we certainly can monitor our own cost, and we do that on a very regular basis to see the part that we're actually directly controlling and if there're any changes in that.

**Bethany Wheeler:** Thank you.

And our last question before we close out our presentation today, is for Donna. “How is data dispersed throughout the healthcare system? Is there a central dashboard?”

**Donna Isgett:** We do have – also put this one online, but we do have a central dashboard of what we call the board report, and it has almost all the value-based purchasing monitors on [it], as well as some others around global mortality rate for the particular institution. So those are what we call our big system measures: mortality rate, performance on core measures, the percent of perfect care we deliver, the eight domain satisfaction. Some of those

scores can roll up into a corporate one for all of McLeod Health, like the performance on satisfaction that you saw on the service excellence domain. But some of them are harder to do that, like mortality rate, because our expected mortality rate at a primary tertiary care facility would be much different than that of a more rural hospital.

We do try to do some of those in an index format, observed versus expected, and roll it up in that observed way. But really, our data gets down hospital specific, or even now in our MTA, practices specific. That we do at our quality and safety meetings every week. And it is an expectation that the senior-most leaders attend these quality and safety meetings on every campus or within our McLeod Physician Associates, on a weekly basis. That's not an optional meeting. That is part of the work of an executive.

**Bethany Wheeler:** Thank you for that answer, Donna.

And I believe that is all the time we have today.

So, Deb, I would like to turn it back over to you.

**Deb Price:** Thank you.

Yes, that will conclude our event for today.

The transcripts and the Qs&As will be posted on our new inpatient site at www.qualityreportingcenter.com, as well as being posted on the *QualityNet* site at a later date.

Thank you and enjoy the rest of your day.

**END**

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