Kansas Healthcare Collaborative
Monthly HIIN Webinar Transcript
April 26, 2017
10:00 to 11:00 a.m. CT

Slide 1 Michele Clark: Good morning. Welcome to the Kansas Healthcare Collaborative's Hospital Improvement Innovation Network webinar. Today is Wednesday, April 26, 2017 -- a nice, cool, spring morning. My name is Michele Clark with the Kansas Healthcare Collaborative. This session is being recorded, and this webinar is for all 117 Kansas hospitals participating in the KHC HIIN. Of course, all hospitals are welcome to join us every month. So, I will go ahead and get us started here.

Slide 2 Today, we will be focusing on communicating progress and value in patient safety. We will take a look at the AHRQ Patient Safety Scorecard and CMS goals that have been recently announced. Rob Rutherford will walk us through the HRET HIINprovement Calculator, and Betsy Lee will be facilitating a conversation around how to effectively use patient safety data. We have a great group of hospital leaders who will be sharing how they share their patient safety data with other staff and board members. Rob will give us an update on our HIIN measures and data, and we'll be talking about resources, and upcoming events. Hopefully, we will have a few minutes at the end for Q&A.

Slide 3 We have a special guest with us, Steve Reinhart, who is Director of Clinical Quality at the Health Research and Educational Trust in Chicago. Steve directs the internal HRET team and partners in support of our HIIN project. He has been working in healthcare for more than 20 years in areas of quality improvement, operations and outcomes research. He was here for our statewide HEN wrap-up meeting in Topeka last September. We're just really delighted to have him back virtually.

We also welcome Betsy Lee today. She's an Improvement Advisor with Cynosure Health and supports the HRET HIIN – including serving as our improvement advisor for Kansas. She will be facilitating a session today with our three guests, including Kristie Hays, Morris County Hospital. Kristie is risk and quality manager there. We also welcome Beverly Myers, the quality improvement risk manager at Satanta District Hospital, and Rachel Merrick, who is the quality director and PFAC coordinator at Labette Health. In addition, Rob Rutherford, our Senior Healthcare Data Analyst is with us today.

Slide 4 First, we have a few announcements and updates. We had a wonderful kickoff training session with our new Cohort 3 PFAC collaborative, helping Kansas hospitals develop Patient and Family Advisory Councils or committees where Patient and Family Advisors are present, and other strategies. We had 35 hospitals participating in track 1 and track 2. We conducted in-person training events in Hays and Topeka in mid-March. This group is well underway.

Slide 5 We also held two regional Sepsis Champion Workshops in Dodge City and Topeka, facilitated and with faculty from Wesley Medical Center/Wesley Healthcare. Much appreciation to Suzie Fletcher, Brett Hartkopp, Dr. Eckengren, and all the faculty who helped lead these outstanding sessions.

Slide 6 Another announcement is that Kansas is joining Cohort 4 of STRIVE. So, for those hospitals that have participated in previous On the Cusp: Stop CAUTI, or On the Cusp: Stop CLABSI projects, this will be a similar style of project. We will be working in partnership with HRET and professional partner groups that will provide expert national faculty for your infection prevention program, and as we work together to reduce hospital-acquired infections and *C. difficile*, CLABSI, CAUTI and MRSA. This is not limited to hospitals that are in the HIIN; all Kansas hospitals and LTACs can participate. HRET will host a kickoff informational webinar on May 1. We have until May 12 for hospitals to sign up, and then the 12-month program will start June 1. So, if you are interested or have any questions about the project, please join us May 1 or give me a call. I will be happy to help share more information about it. We also have a page on our website with a one-page informational flyer. There is a link below for more information. So, you can look at the FAQs and the information about the project.

Slide 7 Many of you may recall in the needs assessment each hospital team completed at the beginning of HIIN, we asked if anyone would be interested in participating in a hand hygiene collaborative. And, yes, we had just an overwhelming response on that. We had over 50 hospitals say they would be interested, and another 46 said, maybe. So, we are launching a new Hand Hygiene Collaborative in partnership with Qualaris. We would like to invite everyone. In addition to STRIVE, please pass this information along to your infection preventionists about an informational webinar taking place on May 4. Individuals can pre-register for this webinar. More information will be coming in your email.

Slide 8 And tying in with hand hygiene -- May 5 is World Hand Hygiene Day. In observance, HRET will be compiling a collage and invites all participating hospitals to share pictures of good hand hygiene practices. Just be creative. If you can do a group shot, I think that would be a lot of fun, too. So, they're looking for your photos by Friday, April 28. So, that's today, tomorrow and Friday to get those done. It would be fun to have a lot of Kansas hospitals in that.

Slide 9 At this time, I am happy to turn the program over to Steve Reinhart has some information about MOC-IV sponsorship, a new development and resource.

Steve Reinhart: Great. Thanks, Michele. And, yeah, I am glad to be here virtually. I'd love to be there in person. I had a great time in September.

We're really excited about our designation as a portfolio sponsor. So, what that means is that through the HIIN work, HRET can function as a clearinghouse for physicians getting credit for their maintenance of certification Part IV. So, Part IV of their certification within their specialty is specifically around improvement in medical practice. So, kind of the shorthand is, by participating in any of the relevant HIIN quality improvement projects, if they have meaningful participation -- and that's a pretty broad category -- they can get credit towards their certification. And ABMS, American Board of Medical Specialties, has engaged 21 of the 24 specialties, so basically almost any physician who is seeking certification credits and advancement, especially for the MOC-IV piece, would be eligible. The idea is that they would then have an incentive to partner with you and your staff on the quality improvement initiatives. I know that we've talked about this a lot; partnering with clinicians is really essential. I know in my own work, when I was back at Northwestern, when we had physician engaged --VTE, falls, CLABSI, anything -- we got a lot more traction and a lot more sustainability.

So, we have details to work out. Essentially, this process would be, the physicians or the hospital would send us what the project is. The project can have already begun, it's okay. We can't do this retroactively, but if a project is in process, really, just a brief description of the project and then at the completion of that will be designated as meaningful. Participation is involvement for about six months or at least two PDSA cycles. I recognize that a PDSA cycle could be within a week, but -- so, six months of work. And the role could be a physician champion. The physician could be on the implementation team, part of the quality committee, but actively engaged in the work. So, we think this is a great opportunity to align the physician partnership work with the work that the hospitals are doing around the HIIN harm topics. So, we've got a couple of references there, and more details to come, but I think those folks that are already aware of it are fairly excited. At least that's the reception we've been getting. So, Michele, I'll flip it back to you so you can officially kick us off here.

Slide 10 Michele Clark: Okay, great. Thank you very much. So, the core of our meeting today is about connecting patient safety initiatives with prevention of harms and cost. And as we learned from visiting with hospital teams around the state over the past few months, we often heard the wish and the need for more effective ways to connect the work that you're doing in patient safety and quality improvement with the bottom line. And the bottom line can be in many forms, including better patient outcomes, patient satisfaction, as well as avoiding unnecessary health care expenditures or potentially earning quality incentives. So, HRET is always on the forefront of developing tools and resources to help you with that. We're going to dive into that a bit today. We also are excited to have several Kansas hospitals sharing about the effective ways of using these types of tools and communicating results with their board. So, Steve, I'll turn it back over to you.

Slide 11 Steve Reinhart:Great Thank you, Michele. And I'm going to kick off with a slide that we first shared, I think at least it was during the CMS Quality Conference in December. This is from AHRQ and their national scorecard, a summary and a reflection of the work that has taken place certainly as part of the HIIN work, but beyond that. All of their work in tracking the harms, hospital-acquired conditions across a number of areas. It's so wonderful to see these results. I know Rob is going to get into the calculator, and having the data and seeing the numbers is certainly part of it. The stories are crucial, the patients, but at a high level a reflection of the work that all of you have been a part of for the last, at least five years that this is -- yeah, five years, this was 2010 to 2015 -- some really wonderful results. The link there, and I believe you have the slides, goes into more detail about which HACs were included and what led to that. The big drivers out of their work here, what they were assessing was adverse drug events. That was the biggest piece of the harms, ADEs. Pressure ulcers, still a big focus for all of us, and then CAUTI and CLABSI. So, wonderful to see this, back to Michele's point. I mean, this makes a big difference, whether you're counting lives or dollars or harms prevented.

Slide 12 Another way that AHRQ has looked at this is looking at harms per discharge. We've used these data and these results as part of the HIIN work, in driving that. It's wonderful to see this progress over time. But as I've pointed out, every time I've shared these numbers, and I usually show it in this next slide here, in the table, it's wonderful to see that progression and to see the goal. For 2019, we'd like to get it below 100. But kind of flipping that around, that still is, in my view, a ridiculously high number in the sense that 1 out of 10 patients are still experiencing a harm in the hospital. And so this is kind of the dichotomy of recognizing the wonderful work that has happened, but much to be done, and we're very appreciative of the work that you guys are doing.

Slide 13 So, with the HIIN, again, the overarching goals are these 2012 numbers, so the 20% reduction over the hospital-acquired conditions, and then for readmissions, 12%. The quote there is from Rick Pollack, who heads up the American Hospital Association, and he set an even more ambitious goal of getting to zero, which I think we can certainly ascribe to. But for now, the tangible goal that we're targeting is, really, let's get this below 100 per 1,000 discharges.

Slide 14 And for those who are not familiar with kind of the development and then how HIIN came, again, we've been doing this type of work through HEN and HEN 2.0, as you folks have been part of that as well. A slight change. For HIIN, the funding is out of the Medicare Trust Fund. The goals were set through the Partnership for Patients work in that setup. HRET and the Kansas collaborative here is part of one of 16 HIINs. So, we're the largest. You're one of 32 states that are participating in this, and we're about 1,630 hospitals strong. And, again, our focus with this work, engaging hospital leadership, I mentioned earlier about the MOC-IV, the main certification clinician, the staff. How do we get everybody involved and focused on the patient? I know that that's been kind of a shift as we continue this work in making them a partner in this work and working with that.

Slide 15 You can believe it or not, my joke here is that whatever state we go to, we always just highlight the Kansas slide, but in all seriousness, I was really impressed when I came out in September with the work and the organization you guys have. And from another piece that is near and dear to me is the fellowship work. I really think that's an important part of increasing capacity for this work, and I've done a fair amount of training with that in my organization. So I really, really appreciate how your hospitals have stepped up and have gotten fellows engaged in the work.

Slide 16 So, as part of the celebration piece and tying a little bit into the AHRQ, our numbers are a little different because we're a large subset of what AHRQ is measuring. But we have, again, should be familiar numbers with both the HIIN, which is the two-year program, and then HEN 2.0. And, again, all told over the course of these two programs, we've got over 125,000 harms prevented, adding up the numbers from the two slides, and over a billion, $1.3 billion, in cost savings across these harm topics. So, we expect to have similar topics as we're tracking and moving toward those 20/12 goals, the 20% reduction in all harms, and then then the 12% readmissions piece.

Slide 17 And, again, breaking it down, we're tracking, and I'll keep mentioning Rob an the improvement calculator. It's such an important part of this work. We know that numbers alone are not going to motivate people and save lives and make patients more safe, but it is a way to know whether we're on

track in what areas kind of globally, and then down in your own organization, where are the focus areas? Where should the focus areas be? So, this is what we're tracking on a national level and what we're targeting both after year one and then end of September 2018, the end of the second year.

Slide 18 So, I kind of alluded to a couple of the aims that we have nationally, and then Michele and her team and all of you have been certainly adopting. We see it in programs like this and then in conversations and information we receive back from site visits and whatnot. But engaging the patients and families. It's important that they can be a part of this work, setting expectations for them. And, again, looking at all harm. Taking this holistic, crosscutting approach to the work, that's how we're going to get these next levels. Early on in the quality work you get that low-hanging fruit; more difficult now to really pursue these last pieces and continue this.

Slide 19 So, sorry, I talk about data a lot. I'm an engineer by training, but to connect with people and understand what this means, it's about the stories on both the patient level and then from your own work within your hospital data. And then, again, we're trying to look and hear from -- I'm so glad that we've got hospitals on the program today. That's how we align this work with what we're sharing, what is being put into place, and then through programs like this international approach, we can amplify and get the word out about what's happening.

Slide 20 I'm going to cover some of this material fairly quickly, because I think a lot of you are aware of this. Michele alluded to what we can do and what we are charged with in helping with the HIIN. And it's providing these resources and listening. A big part of our work, we're a little bit over six months into the HIIN, we need to know if what we're providing is working, and we're asking and surveying. We don't want to continue doing things that aren't of value or don't have kind of some stickiness with you and your team.

Slide 21 So, we're delivering this in a variety of formats. We've done early on with starting up the HIIN. We've done the site visits. Hopefully, people take advantage of the listserv. Every now and then there is just a wonderfully, meaty discussion, and I think those can be helpful. Again, we can provide a lot of content from the national experts, and I always find, though, that the sharing among the hospitals, that's where it works, because that's where the work really gets done. We can't get to that level of specificity without some of the change packages and the webinars that we do, although certainly having hospitals on and sharing that is part of the work.

Slide 22 So, this is where we kind of try to reach out and connect. We have our virtual events, webinars, podcasts. We've heard, at least from some physicians, it's kind of a good way where they can catch bitesize portions of information and share that. This is the SNAP, the Safety Network to Accelerate Performance, where we kind of have a small group focused on -- now we're doing enhanced recovery after surgery. I think it's a great opportunity for learning. Betsy and her team having helped develop the UP Campaign, and we've talked about sharing the new crosscutting pieces. We talked about fellowships, and then the roadshows, where we can get out and get with you in person, focus on topics that are relevant to you, your hospitals in Kansas.

Slide 23 Again, the change packages, I think we've got just a couple more. We've been revamping them as we've transitioned from HEN 2.0 into HIIN, and the tagline we've been using, as you can tell, if they're blue, they're new. So, this is the look and feel of the updated change packages. So, those are available on the website.

Slide 24 I think that is a lot of good material, and you guys can kind of decide what's relevant and what works in your organization. Certainly, Michele -- and my contact information is there, but she can certainly find anyone on our team to help you. And, again, we want to change this up as we go. Things are not working, let us know and we'll refocus and come back, but we really value the work. I know that what happens -- any of the progress, any of those wonderful numbers that I was able to share from AHRQ and from the HIIN and HEN 2.0 work is because of what you and your teams are doing on the ground. So, I've mentioned Rob a couple of times. I will officially hand it over to him as he walks us through the improvement calculator and how you guys have been using it.

Slide 25 Rob Rutherford: Thanks, Steve. Hello, everyone. The new HRET Improvement Calculator has been released. Hopefully, a lot of you are excited about that. It's another way to look at your information and your data. We're planning on rolling that out late next week, I believe. So, this is just another great tool. Some highlights. It's a completely new redesign, so some of you that may have had some issues, technical issues in the past, they are hopefully going to be resolved.

Slide 26 Some other features, there is now a single unified dashboard. It's not an individual task for each measure; it's all in one place, which makes it somewhat easier to use. And then the big things, for me at least, are, they have extended the cost savings to other harm topics, and more importantly they have started including mortality. So, not only can you look at it from the number of lives saved, which is really meaningful when you're trying to convey the information.

Slide 27 So, the new design for the calculator is a pretty standardized layout. There are instructions. There is a data area, although we will be prepopulating your data.

Slide 28 There is the dashboard, which I'll get to in a second, and then there are some summary tables, and then additional methods and references, if you're interested in where those cost and mortality estimates are coming from.

Slide 29 So, once the data is in, we can hit up at the dashboard page that will give you a look at the charts.

Slide 30 So, this might be a little difficult to see on your screen, but these are going to be pretty familiar charts for you guys. The top left one is the measure rate, the top right is harms prevented, the bottom left is a rate per discharge run chart, and then the bottom right is going to be lives saved, which is incorporating that mortality I mentioned. This particular one is a preliminary. I believe I was looking at falls for our statewide HIIN. And you'll notice on the right-hand side, you can actually look at kind of a table of the total numerators and denominators for the month. For you guys it's just your hospital, obviously it's going to be a lot lower.

Slide 31 And when you're trying to use this, this is kind of a zoom-in on that selection area that we selected those charts. If you want to look at an individual measure, you'll select it on that right-hand column. The left-hand side is just going to show you individual hospitals, just kind of looking at kind of the statewide rate.

Slide 32 The next piece of the improvement calculator is the summary table. This is a one-stop table summary where all of your measures are at. So, if the other slide was single charts per measure, this is going to just aggregate it all together. And the two things I would kind of like to draw your attention to are the very right two or three columns. So, those are going to show kind of your year-to-date improvement. So, this is over the course of the project so far, from October to February, because that's the most recent information, and year-to-date rate. And the other thing I wanted to point out to you is at the very, very bottom there is a total harm line, and that is going to aggregate all of the harms, that harm per discharge that we were talking about. Similarly, the next tab, which is table per discharge.

Slide 33 And it's kind of an aggregate or per-measure basis. And, again, the dashboard is per measure. The total harm, when we're looking at it in those tables, is going to include all of these. This is also explained in the calculator, so don't be super worried about trying to track it all at the moment. But, again, the summary table per discharge is going to show us that harm per discharge.

Slides 34-36 So, Steve was talking earlier about how our CMS goal is 97 per 100,000 discharges, and right now our baseline rate is 108 per 1,000 discharges, and our current rate so far is around 104. So, we're showing some improvement. We're heading in the right not quite where we'd like to be yet.

Slide 37 So, there are some basic questions. We've demoed this to one or two hospitals, and the, kind of, where are the instructions, that first page. There are some issues using Excel 2003, so the recommendation at this point is Excel 2010 and above. If we run into any issues with that, please contact us and we can work with the HRET team and try and figure something out that will work.

Slide 38 So, this is one question. The numerators and denominators may not match on the dashboard, on the data tab, and this is particularly going to happen to the baseline, because it's converted from -- as you may remember, the baseline is going to be a three-month, six-month, year-long, however long it is. They convert it to a monthly, standardized rate, so it's comparable to everything else.

Slide 39 There are a few other FAQs that are certainly available.

Slide 40 If you need more information, is on the HRET data page, and there are some tutorial videos on using the tool. So, now I will hand it over to Betsy and our hospital speakers. Betsy?

Slide 41 Betsy Lee: Thank you so much, Rob, and hello, everyone. I'm really excited to be with you today to really address this issue around raising the bar, and how do you bring quality and safety to the board in a meaningful way.

Slide 42 So, what we're going to do is to really -- I'm going to turn it over to our three hospital speakers. We're going to hear from Beverly Myers and Rachel Merrick, and then, finally, from Kristie Hays. And they are going to go through some stories about how they have really advanced their learning in terms of the way that they present quality and patient safety data to their board of directors and senior leaders. So, first of all, let's hear from Beverly about the experiences that she has had at her hospital and in the health system at Satanta District Hospital. And, Beverly, if you could give us a little bit of background about your story, then we'll maybe follow up with a couple of questions and move on to the other presenters, and then see if we can have a little bit of dialogue before I go through a few summary slides. So, I'll turn it over to you, Beverly.

Beverly Myers: Good morning, everyone. This is Beverly Myers, and I am the risk manager and quality director here at Satanta District Hospital. And we are a small CAH hospital, 13 beds in southwest Kansas. We started taking a look at -- well, we started, actually, when I started working here in 2012, and just built it from there. But the calculator, I thought, was very helpful in showing the board in particular how preventing harms saves dollars. So, we used that calculator and we presented it to them. And actually the administrator does the presenting except for one time, we decided we want to go in, present these numbers to the board, and get direct feedback from them. So, we did that. We went in with a specific goal in mind of showing them how nursing interventions and interventions across-the-board save harm for the hospital and in that way saves dollars. And we did that to show them that quality does matter. It makes a huge difference in your hospital, in your patient satisfaction scores, and all across-the-board.

Involving patients and families also was a big push, and we did that in a way that we could -- so that we could use those incentives to supply things for the nursing staff, the boards in the room, the whiteboards, to help patients and families engage with our staff more effectively. We also used it when we wanted to start doing things in the rooms to -- like having bedside report, and we started that in 2014, I think it was. And it's been very successful. I think it is the one thing that helped us prevent falls. And when you come to them with that data and you're showing how preventing falls saves you this much money, it really makes an impact on them, because they see how you tie those things together and all that correlates in saving harm to a patient. And I always bring it home to say, you know, if that was your mom or dad, what would you want for them. And so that's kind of how we did it.

We also used other kinds of data, like, they really like the QHi data, because it has the bar graphs, and they like to see how our hospital compares with other hospitals in our group. So, we use that, too, as a tool, to show them what we want to do. We wanted to join the sepsis campaign even though we don't do colectomies or anything like that. We do want to use it anyway. We want to make people aware of what sepsis is.

So, in our small community, it's very important that we be ready for whatever comes across. So, we use the information, we gathered all the information for a year of all of those people who had criteria, the SIRS criteria or met SIRS criteria that we missed. So, we said we took that to the board and we said this is how many people we could have helped had we known this stuff. And if we had the capability of running the levels in our lab, then we could actually -- the lactate levels would tell us what we're

dealing with. And so we got approval to have our lab run lactate levels. That's a system improvement. It was a huge step for us. So, I think using that data and taking it directly to the board made a huge difference in our ability to be more active in the HIIN, and more active in our hospital, and have us more visible to our staff and what we're doing, and how we can make an impact on things.

We still are striving. We have a lot of zeros across-the-board. We haven't had a fall since last August, so we're doing really well with that. And I think just keeping all of this in mind and keeping people aware of what changes are coming across, what things are important. Because you can do all this stuff and nobody would see this unless you make it visible.

Betsy Lee: Right. Right. Yes, Beverly, this is so powerful. I love how you've integrated the use of the data with the personal aspects of it, to kind of bring it home. So, we'll come back to that in a few minutes. I want to turn next to Rachel Merrick at Labette Health, to hear from her and her story about how they actually started presenting the data to the board in order to make change and impact in her community. So, Rachel, I'll turn it over to you next.

Rachel Merrick: Hi. As she said, my name is Rachel Merrick from Labette Health. We are licensed for 99 beds. I wanted to explain how we use the calculator. We really use that harms per 1,000 patient days, that big overview chart that was provided in the previous calculators, to give an overview of, yes, this is how many harms we've prevented, and this is how much money we have saved as a way to finally tie in. Though we kept telling them that finance and quality went hand-in-hand, it look a little bit for them to really get that marriage established for them. We had told them before with value-based purchasing, this is how much is involved, we're going to get X amount back; this is how much is at risk. But with some of that we didn't always have the dollar amount. With this calculator we were able to provide that dollar amount to be able for them to see how much of an impact we are making for the facility as well as for the patient safety. Even though we do provide that overview of the harms per 1,000 patient days, when we got to our presentation, where we talked about readmissions or any of the other topics, I would use the calculator and provide that information saying that we had prevented so many readmissions and saved X amount of dollars. That way they could see that each of these elements that are part of the HIIN were contributing to that big overall as well. And we take our information to our quality council, which is our department heads, but then we also share that overall with the medical staff, and then on up to our board quality meetings, so they can see that overview and see what kind of impact we are making for our patients, both financially for the facility and for patient safety as well.

Betsy Lee: Rachel, thanks so much for that explanation. I think what really strikes home for me is how you really use the tools that were available to do some sense-making and make it real for your board of directors, and kind of that linkage from the data back to the patient, and also with the cost savings that were involved. So, really kind of creating that storyline, if you will, throughout the course of your board meeting. So, what I want to do next is to turn it to Kristie Hays. And, Kristie, I'm going to switch over to your slide that describes some of what you're doing. So, I'll let you explain what you have here on this little storyboard.

Slide 43 Kristie Hays: Okay, thanks, Betsy. My name is Kristie Hays from Morris County Hospital in Council Grove, Kansas. We are a 25-bed CAH hospital. And I use the improvement calculator monthly, when it was available that we could put our data in separately. And this board started because I was updating it monthly instead just a quarterly report. Employees were kept up-to-date on what was happening along the way. And I made it Chasing Zero because one event for us makes those graphs really dramatic, because we don't have that many patients. So, Chasing Zero is definitely what we're striving for is to get all of those at that level. And the stars on there was kind of a way of telling them where we were at, if we were making improvement, if we were at our ideal, which, of course, was zero. And just a little bit of an update for that.

So, when the improvement calculator changed and we could put our things in monthly and blow them up and things like that, like I could do with the other one, then I started calling Rob after the end of every quarter and having him send out this report. And I print those out and put them on the board instead, and they seem to like the visual of this. And it's just in our dining room when it's updated, and

it keeps our employees updated on what's happening with our improvement projects. I also, of course, submit a quarterly report that is distributed to the medical staff, and I go to medical staff and give that report. It gives our physicians a little bit of heads-up of what we're doing, how we can change getting feedback from them, which they're very good at letting us know in that communication there of what we can do to improve the safety as well. And also we let them know what's coming up next, what we're going to be measuring, and the different projects, like sepsis and such.

Then I also submit the quarterly report at the board meeting every month. I've done that forever, so it's not been anything new. And I think that they like to hear it from the frontline staff, basically, because I also am involved a lot with the nursing part of that. They are able to ask questions, and I think it's made it clear for them what's all going on. I do miss the harm across-the-board, so I am glad that that's coming back, because for us with very small numbers, that was kind of more meaningful to us, and it all makes it -- with the dollar amount on it, it makes them apply that as well.

Betsy Lee: Thanks so much. I really appreciate this Kristie, because what you've done is to really be able to find ways to make it real for the employees, for the physicians and providers, as well as for the board, and really linking to some of those reports and the graphs that are available through KHC, as well as what you're doing, and kind of that linkage is on the impact of small numbers. So, that's really a terrific way to do it, and to be able to update it on a regular basis. We do have one question in the chat for Beverly from Stacie asking about -- really, commending you on your ideas and glad you're having such a strong board response, but asking what kind of response you are getting from your providers. So, maybe Beverly, if you could respond to that. I know really what Kristie described was this connection as well to the medical staff, and I presume you also have the same kind of connection with your physicians. So, maybe you would want to spend a couple of minutes describing that as well before we open it up for a little bit more general discussion.

Beverly Myers: Yes, I, too, also take this stuff to the medical staff. Medical staff, some of them are onboard immediately, some of them are kind of skeptical about some of the changes we want to make. We started with really getting wound up with this stuff when we became a trauma Level IV designated center. And so they were skeptical, but when you present them with the numbers of people that came through our ER that were missed with the SIRS criteria, and that one in particular spoke to them. You know, (inaudible) and what they're doing and then tie it back to patients and how it impacts them, that's the thing I try to do in the medical staff meetings. Because doctors really do want to do a good job. They want to engage with their patients, they want to engage with their staff, they want a positive outcome. So, with these kinds of things, we had a positive outcome, but could we have done better? Could we have made a difference in this person's life? Maybe we wouldn't have had to wait until they were really, really sick and then ship them somewhere else. If we could have found it early, could we have kept them here, where their families are? And that kind of stuff really speaks to them. It brings them onboard and it --

Betsy Lee: Right.

Beverly Myers: If you ask a doctor, this is what we can do to help this person, or even one person, would you do it? And their answer is going to be yes.

Betsy Lee: Right. Well, I think what's really important about what you're describing is that that opportunity cost that you had in terms of the opportunity loss, to be able to treat some of those people and giving those numbers, and then also making it personal. So, I just want to kind of put a question out there and I think we can have people chat in their responses to this, about the impact that they are having about whether the quality directors are actually the ones who are presenting the quality and patient safety, or the patient safety leads. Are you the ones who are presenting the data directly to the board? I'd like to hear from some people in the chat, and maybe we can then also hear -- it sounds like all of you are the ones who are giving that feedback directly to your boards as well as to your providers. And I guess my question is, are there things -- other things that you think really lend that meaning to the way that you do it? You've given us some really great examples. I haven't seen any notes yet in the chat for people to talk about whether or not they're giving the data directly or not. So, maybe what I'll do is just see if any of you want to share one quick story. I know, really, Beverly, from you it was the

SIRS criteria and the lost opportunities. Rachel or Kristie, were there other things that you felt like somebody really had an aha moment when you were giving a presentation based on the way that you were sharing with your board?

Kristie Hays: For ours it was in HEN 1.0 with early elective deliveries. It made a huge impact, just speaking with the providers and letting them know what we were monitoring, what best practice was, and we saw an immediate change.

Slide 44 Betsy Lee: So, really just bringing that data up to them from both what the current practice was as well as what the evidence was showing, that's great. And I'm seeing a few things who are -- people who are chatting in. Some of them, I know Elizabeth Irby is saying that she does present to the board; however, they've been told they don't understand the information. So, I think bringing it in a way that is meaningful is also very important. And Cody states that as a quality director, presenting data directly to the board quarterly and then other months the CEO shares something that is taken to them. So, that's great kind of having that blend. We're also seeing that hospitals in even the small critical access hospitals are presenting data to their boards and that some of the data (inaudible). Why don't we move on --

Slide 45 Unidentified Participant: Our biggest aha moment was after we started working with the HIIN, when we started working with our adverse drug events and our naloxone use, with teamwork and everything, the board doesn't quite see all the intimate details of what we're doing. So, when we were able to show them that we had a 72% reduction, a 92% reduction, and even now what we'll be showing is we've had three months at zero, that has been speaking volumes to, like, they are really working at this, or really focusing on patient safety to prevent these aspects. And when they see those big jumps, even if it's a small jump, if it's something that you're really working on, I think that can speak volumes to your board.

Betsy Lee: Right. And I think I'm going to quickly go through just a couple of things here to really show what I think is a big impact on what you're talking about, which is that time series of reduction. So, I know a lot of boards are really shown dashboards.

Slide 46 I think it's important for us to ask the question, are the data easy to interpret and easy to make decisions about taking action? So, when you see data, some of these graphs that are good for comparison may not really be easy for our community board members to understand.

Slide 47 So, what's important is we want them to understand variation, and what is normal variation and what's special cause variation. And I think the best way that we've found, and we've talked about it many ways over the course of the HIIN, is that the way to know which is which is to use run charts. It's hard to tell from snapshot data, bar graphs or histograms or tables and dashboards that you really have time, dates, changes that are resulting in improvement over a period. And so looking at the power of this all-cause harm reduction and lives saved and the cost impact, as we've heard from the hospital presenters today, and the link back to making it personal for patients, I think those are some key principles that you can use.

Slide 49 And I'll just show one example of an annotated run chart that gives the opportunity to tell you when you started, different interventions for -- this one happens to be on anticoagulants. But when you started doing the monitoring versus looking at other interventions along the way, opening an outpatient clinic, this is how the board really understands how rapid cycle tests of change are able to contribute to a reduction that will be lasting and sustainable.

Slide 50 So, what we want to do as well is just think about the stories. I know we need to wrap this segment up to give it back to Rob, but I just want to summarize that a lot of the things that I'm seeing in the chat about aha moments, there was a great one from Christine Winkle, who said that the medial staff lightbulb moment was Foley catheter usage. And the statement here, "Oh, you mean it's not acceptable to place a catheter if the patient requests one?" And really being able to then look at the reduction in catheter utilization, and obviously, then, that impacts the reduction on looking at catheter-associated UTI.

Slide 51 So, really love the chat and all the things that people are saying about making these connections that are personal and telling, and all of the stories that all three of you have shared about the importance of looking at the time series data and linking cost to quality, as well as getting people involved and helping them understand data so that they can take action. So, with that, I'm going to turn it back over to Rob, and I know, Rob, there was one question for you that had to do with some of the improvement calculator work. So, as you wrap up, maybe you can take that one. Thank you.

Slide 52 Rob Rutherford: The question was once data is input into QHi will it be auto-populated? Yeah. So, once you guys have submitted the data, it will be auto-populating for you. It's not going to be a 10-minute thing, because I'm going to have to pull it down and do all the stuff to it and put it back in, but we will be auto-populating. And we are working with HRET to make some -- hopefully, do some improvements with the calculator. So, once we get the next version, we will release it back to you guys, so there isn't a date on that yet.

Slide 53 So, jumping in all of the rest of my stuff, milestone 4, what our progress looks like, the activity survey and some new data information. So, our next HIIN milestone is that all HIIN data are current October through February by May 1. Obviously, going for March is even better, but please help us meet this target.

Slide 54 So, next I'm going to jump into kind of the preliminary how we're doing on our project, on our year-to-date. So, all of these slides are going to have a pretty similar setup. There is going to be table at the top, which is going to talk about the baseline per 1,000 rate, our year-to-date rate, and then kind of our year-to-date improvement and where we're at with the progress. The graph on the bottom is going to look very familiar to you from our analytic reports. The dashed line is our state HIIN baseline. The kind of small dot green line is the national HRET HIIN, and the gray line is our state Kansas HIIN. So, our goal, of course, is to have the gray line in that green target area.

So, anticoagulation with warfarin, we're showing some progress in that. We're not quite where we want to be yet, but we're kind of working our way in that direction for the most part. Oh, and my other caveat with all of these, of course, is that February data point is going to be a little wonky because not everything was in when these charts were done. So, anticoagulation warfarin, we're making some progress. We're generally headed in the right direction.

Slide 55 Hypoglycemia is, again, generally headed in the right direction. This is one of those wonky data points I was talking about. We're still missing, I want to say 20% of the denominator information there, so I expect that to come down. But generally speaking we've been doing very well with the hypoglycemia measure.

Slide 56 Adverse drug events, opioids, this has also been doing very well. We're going in the right direction on that one.

Slide 57 CAUTI is doing fairly well. I'd like to see it go down maybe a little bit more, but we're making good progress there.

Slide 58 CLABSI is one we're having some struggles with, so expect us to really kind focus in on that going forward. We're kind of fluctuating about the HRET rate, and hopefully we can get that a little lower in the future.

Slide 59 Falls with injury. We're kind of fluctuating around the baseline. And, again, this is another little bit of a wonky data point, but we're kind of fluctuating around our baseline and we're not really showing improvement with this yet. So, we're going to be looking pretty hard at that going forward as well.

Slide 60 Pressure ulcers. This is another one that we're kind of fluctuating fairly steadily with, that we'll be looking into.

Slides 61-64 SSIs just in general are doing very well comparatively. So, that's looking very good. We're at a 64% improvement over our baseline. Hysterectomies, again, 56% improvement. Hip replacements, again, looking very good, and knee replacements also looking very good. So, hopefully we can keep that movement.

Slide 65 C. diff is an area that we're kind of fluctuating around the baseline again. We had a little bit of improvement over the course of the project so far. We'll be kind of looking at that and hopefully the hand hygiene collaborative piece that Michele spoke about earlier will be helpful on that.

Slide 66 Ventilator-associated conditions, this is looking fairly good so far.

Slide 67 And readmissions, this is one of the measures that we've experienced in the past that has been somewhat hard to move. We're looking very closely at that. And one of the big things I kind of want to emphasize, especially when we look at our statewide harms per discharge and so on and so forth is that readmissions is one of those measures that impacts everyone, right? There are all of the incentive and reimbursement elements to it. And then just from a sheer numbers perspective, the only people that are at risk for a CAUTI are those that are getting a catheter. But everyone that comes into the hospital in some sense, at least, is at risk for a readmission. So, anything we can do to move that even a little bit is going to have a very large impact in terms of the overall harms across the state.

Slide 68 There has been a quarterly activity survey that's been out. If you have not completed it yet, please, please get to it by COB today, if you have not already done so. There are some interesting preliminary findings in there. There are a couple questions about how your facility defines hypoglycemia, how your facility defines excessive INR for warfarin, and so on and so forth. One of the findings was that of those that have responded already, about 40% are changing or planning to change, or have changed their EHR since October 2016. So, if you guys find yourself going through that process, which I know can be quite complex, realize that there are a lot of other hospitals that are in the same boat. So, it should be possible to reach out and maybe find someone else who is dealing with the same things you are. You're not alone, though.

Slide 69 And other news, we sent out our analytic reports the 21st, I believe, last week. Please review and share, if you have not already done so.

Slide 70 One thing that we've been getting some traffic on is information requests related to Blue Cross Blue Shield of Kansas. Quality-based reimbursement program gives you a nice little payment bump if you submit and meet some of their quality metrics, and so on. If you need educational reports, those are available upon request from Alyssa Miller.

Slide 71 A couple of their measures, that information, they want some numerator/denominator data for, I want to say adverse drug events. I haven't looked at that form in a couple of days. But that information is available a couple of ways. It's shown in our analytic reports, that little side magnifying glass data is going to show you individual monthly numerators and denominators, depending on what timeframe you need or dependent on what data report you want to look at.

Slide 72-75 Another way to get to it is through QHi. If you were to log into QHi and hit the Reports button, select whatever time range you want. This one is January to March 2017. Select the measure or measures. I've just shown patient falls with injury here. And then scroll all the way down and there is a new button called Raw Data Reports. It will download an Excel file that you can open up and it will show you your monthly numerators and denominators for whatever time period you want to measure or measures you selected. And that's another quick, easy way to get that information.

Slide 76-77 And other news, there are some new data collection factsheets that HRET has released. So, there are kind of two ways to look at these. There are those change packages, which are really on the clinical side, the practice side. And then there are these data collection factsheets which are a little more oriented in how you get the information and where you should get it from, kind of things to look for and things like that. And that link is down there, it's on the hret-hiin.org website. And this is a couple of selected items from these factsheets. So, for example, warfarin. And, again, some of this is about

spreading the word. So, this is not all on you as the quality improvement director or -- it's not all a one-person job; this is a team effort. So, looking at warfarin, can your lab provide you a count of excessive INRs? Can your pharmacy provide you the number of patients on warfarin? If you've got low numbers, certainly. Other things, it's not always a technical solution and it's not always necessary to pull it, or try and pull it out of the electronic health record or the EMR. Putting a reporting sheet or a sticker or little pull tabs that you've thrown in a box are all options, especially in looking at these adverse drug event measures. And there are some other tips, too, about where to look for or how to make it as low effort as possible. As I told some of you, when we have calls on some data questions, a chart review is the absolute last thing that we want you to be doing ever. You have other things you need to do, so the easier we can make it the better.

Slide 78 Just a reminder that the March healthcare-acquired condition measures are due by the end of the month, and the readmissions for February are also due by April 30. So, keep that in mind as we're going forward. And I will now hand it back over to Toni and Michele.

Slide 79 Michele Clark: Thank you very much, Rob. I'm just putting into the chat, we have a link for our next HIIN webinar, so I'm just going to go ahead and give that to you. And I know we're about at the top of the hour. Most of the rest of this information we've included in our email, our HIINsights Newsletter that you received a couple of days ago. But I want to go ahead, so we'll just skim over it pretty quickly, but if you can stay on with us it would be great. But, Toni, could you give us a little update on the 9th Annual Summit on Quality?

Slide 80 Toni Dixon: Sure. Thank you, Michele. I just wanted to mention to you all that the Ninth Annual Summit on Quality is Wednesday, May 10 at the Hyatt Regency Wichita. The conference is presented by KHC and the Kansas Foundation for Medical Care. The topics are focused on leadership and innovation in quality improvement and on patient safety. The daylong event will include keynote speakers, breakout sessions and poster presentations. One of our keynote speakers is Laura Adams with Rhode Island Quality Institute and she will present Connecting the Dots: Collaboration as a Survival Strategy for You and Your Patients. And another keynote speaker will be Dr. Thomas Gallagher with the University of Washington. He will present Responding to Patients after Adverse Events. During the conference we will announce the recipient of the Leadership in Quality Award. This award is sponsored annually by KaMMCO and it comes with a $5,000 cash prize. There are continuing education credits available for nurses and adult care home administrators at the conference. And to register or to get more information, please go to the KHC website, and I'll give you that address. It's khconline.org, and look for the Summit on Quality. We have a great agenda planned for the day and we hope you will join us. Thank you.

Michele Clark: Okay, great, Toni. In fact, if you could, you might just put that link to the registration in the chat, so that would be great.

Toni Dixon: I will be happy to do that.

Slide 81 Michele Clark: All right, thank you. Okay, so there is a question from Natalie about what type of information is contained in the educational reports? It's basically a list of all of the educational opportunities between KHC and HRET HIIN that anyone on your staff may have attended. So, for example, if your incentive is to attend at least five educational events over the last six months, then we can easily pull that list for you. So, it's just an email that we'll send you. So, I'll tell you what, Natalie, we'll just go ahead and send you one so you can take a look at it.

All right. So, moving on real quickly is just some upcoming events. And we have a full -- HRET has a falls webinar on May 11. The Rural CAH Affinity Group will be on May 15, with a focus on antibiotic stewardship. And then the Partnership for Patients, CMS, this is like an HIINs, the Partnership for Patients HIIN events are all HIINs, so they're going to have a Patient and Family Engagement virtual event on May 15, as well as pressure ulcer, and it looks like we may have an incorrect date on that. So, we'll double-check that and update that in the next email for you.

Slide 82 Upcoming fellowship events are May 3 for the Patient and Family Engagement. Quality Improvement Fellowships are back-to-back on May 10. And I do just want to point out that even if you're not formally participating in the fellowship this year, you are certainly encouraged to audit and attend any of the virtual fellowship events. If you are participating in the HRET HIIN, you are eligible to do that.

Slide 83 Also, in addition to the PFE Fellowship, HRET has a five-part series for Patient and Family Engagement, so this is not a part of the fellowship, but it is for everyone. It's the Big Picture, and on May 23 will be the third session. So, the previous sessions have been recorded and they are posted on the HRET HIIN website. So, I'll see if I can get those links and get them out to everybody in case you'd like to review any of the past ones as well.

Slide 84 All right, so the adverse drug event, the Fishbowls are about to start, so the first one will be on opioid safety. There are five hospitals that are going to be in the Fishbowl, so it will be fun to watch along with them and participate as they go through their plan-do-study-act cycles over the next five months.

Slide 85 And then the readmissions Fishbowl will start May 25, and we're really thrilled that Ransom Memorial Hospital in Ottawa will be a part of the readmissions Fishbowl. So, be sure to join in and cheer on Team Kansas.

Slide 86 And then also put a link in the chat for our next webinar. In May it will be our regional webinar, South-Central HIINergy Group. Louisiana will be taking the lead for this call, and we'll be talking about patient and family engagement. So, registration link just opened this morning. That link is in your chat, and we'll send that out to everybody as well in an email.

Slide 87 And then, also, just want to remind you, our monthly webinar schedule for our alternating Kansas webinars and our regional webinars. In addition, I want to be sure everyone saves the date for November 14, 2017, for an in-person meeting. We're working on scheduling, venue, and identifying the topics and speakers. So, give us a few weeks, we'll be getting more information out for you, but I just want to be sure you save the date on your calendars.

Slide 88-89 All right. I really appreciate everyone hanging on with us. So, I think in the interest of time, let me check and see if there are any other questions in the chat. I'm not seeing any. But as you know, you can contact your KHC team at any time. Be sure to contact Rob for any questions with your data and measures, and Alyssa can help with your educational reports. Toni is a good contact for you on Summit on Quality. And then, of course, contact me for anything that you'd like. I want to give a huge thank-you to Rachel and Bev and Kristie for being a part of our webinar today, as well as Betsy Lee and Steve Reinhart. So, thank you all for joining us and we'll look forward to seeing you hopefully at the Summit on Quality on May 10. Thank you all. Bye-bye.

Operator: And this ends today's call. Thank you for your participation. You may disconnect.