This transcript is intended to provide webinar content in an alternate format to aid accessibility. We apologize for any inaudible or unclear content as a result of audio quality.

Sharing Our Best Practices: Fairview Northland Medical Center
Core Measures Meeting for PPS Hospitals
Quality Reporting and Improvement

Presented by Jackie Popp, RN, BSN, CPHQ, Quality Director and Deb Rauch, RHIT, Data Analyst, Fairview Northland Medical Center. (40-minute webinar) (10-09-2012)

Jackie Popp: My name is Jackie Popp and I’m glad to see my partner Fairview people here. I am the Quality Director at Fairview Northland in Princeton. My title is Quality Director, so I have responsibility for CMS core measures and the abstraction is built into our design. My partner here Deb Rauch will be talking to you today.

I’ve been with Fairview for 26 years, pretty much all in quality, although I’ve been a bedside nurse as part of that as well. I’ve also been around nursing longer then that, but as far as core measures and CMS goes, I’ve been with it since it was a pilot project with CMS. It’s been a long time; this is a long road for us.

I’m going to spend the next 45 minutes talking to you about the best of our best. I want you to know our best kept secrets, maybe they’ll fit you, maybe they won’t, but we want to share them anyway and make them totally available to you so you too can be a success in any way, shape, or form.

I’m sure my family members are probably at your facilities trying to get excellent care and that’s what we want.

Deb Rauch: I’m a Quality Data Analyst at Fairview. I’ve been with them for nine years. I came from 1:27 where I was doing similar things. I started with CMS and core measures when I came to Fairview.

Jackie Popp: I’m a Quality Data Analyst at Fairview. I’ve been with them for nine years. I came from 1:27 where I was doing similar things. I started with CMS and core measures when I came to Fairview.

None of you can have her I don’t care what you say, don’t try stealing her away. Let’s get started. I’m going to have Deb doing the keyboard for me. Does anyone know where Fairview Northland is? Well we’re one of the six Fairview hospitals, you go north to Rogers and go north some more on 169 and you’re at our doorstep. It’s kind of your way to the north woods.

To give you an idea about our size, we’re a smaller facility so we’ll have a monthly average of around 150 inpatients. We’ll have ED visits around 1,300-1,400 and that’s our size. Deb is the one abstractor for all of inpatient/outpatient CMS or core measures. She does it all and that’s not her only job. I’ll describe to you how we maximize this young lady. She’s very talented, expert in our definitions.

Just wanted to throw in an example of this, we’ll be talking about our process measures, the ones that are CMS and core. We’re not really talking about the satisfaction components, so I wanted to bring that to your attention. In your handouts, Bolles is a small town and I want to put this concept here so that it gives me a chance to tell you a story.
Sometimes we struggle with how to engage people, how to make them know what kind of goal we’ve set and why that’s important and why missing one core measure is important.

One of the stories is about Bolles. I am a top 10 graduate from Bolles which is good right? I am really the second in line from the top, and that’s really good. People know it in my town and it should be across my chest or my head that she is one smart girl. Now, if I set my sights on Harvard, I’m going to Harvard. How is Harvard looking at me? We’re in a different game. We have a different goal, different competition.

If I choose to be at Harvard I’m going to have to adapt to that and step up my game and be proving that I’m also top decilee in Harvard. There’s no doubt that the people in Bolles still consider me top performer, but I’ve signed on to Harvard so I’m in that game. It doesn’t mean I’m less of a person. It doesn’t mean I’m less than anything it’s just that I’ve chosen to be.

So Northland has chosen to be with the rest of Fairview, part of the top 10 of the nation. We aren’t satisfied with just being top in our community of hospitals. Sometimes it’s adopting a story so you can connect with people. It’s not that you’re bad because you fail to measure, it’s because we’re in a different game here.

These are the four shared learnings that are our best. These are the four things we picked to share with you about CMS and core measures.

1. Preparing everybody, the whole team six months ahead.

How do you do that? When you all get into your agenda and talk about DTE that’s starting January 1, oh my gosh, where is the six months ahead that I can do that? Today I’m going to challenge you to think about how you might structure yourself and plan to be able to do that.

What we’ve got in our design is probably different from your design for how you use your abstractor. Think about using your abstractor as the consultant, the most expert person in the data definition. That’s probably how you know that person to be right now and maybe you are that person. Think about moving them in to participate in the teamwork.

These are the monitoring sites that Deb, as our abstractor, has to keep a lookout on. She’s not waiting for Stratis necessarily or waiting for other vendors, she’s looking herself and she isn’t alone in that, but the accountability is with her to be the early alert. We want to know six months ahead so be looking with that in mind.

2. The next point on the slide is really about what kind of team she needs to do her work?

With our small facility and actually with any population that you would have, whether it’s all the populations or one, putting the abstractor with your best Nike nurse or Nike leader and I say Nike because they’re the just do its. They are the one’s that are talented in improvement. They’re creative in tools. They know the workflows and the culture. You grab that best person and pair them up with a data abstractor who knows all the definitions and you have one dynamo group, just two people.

That’s leader/champion in that abstractor is starting the implementation planning on anything six months ahead. They have to translate the data definitions into workflows, tools that already exist and into roles, whose job it’s going to impact whatever the measure is. You want to use things that are already in place if you possibly can, but you already know that.

Deb’s going to take over now and she’ll talk to you a bit about some of those example tools we’re talking about.
Before we do that I’m going to say a little more because I have one slide yet. I wanted to also go beyond that twosome the abstractor and leader, the champion of your population. We have expectations of each caregiver and position, so all caregivers are expected to understand CMS core measures. They have tools that they’re expected to use consistently.

Some of the things I’m sure you have in place like checklists, resource lists of some kind, any kind of prompts and little signs. I’m sure you have dozens of things. One of the extra things I thought to mention is handoff communication. It’s an expectation that if you’re handing off a patient from unit to unit or nurse to nurse on a shift, whatever it is, that the information include that this is a CMS or core measure patient and this is where I am in that.

It’s also order sets and protocols, I’m sure you have that. It’s also what your accountability is or what your structure is when a patient has been admitted without a CMS or core measure diagnosis, but during the hospitalization they change and become one. Then what? What do you have in place?

We will then have charge nurses ready to notice that, look for that and speak up about that, that might be in the huddle with your physician to make a safe catch right there and start the works, implement the tools. So it’s not really just someone walking around trying to catch and when that one person goes on vacation you’re up a creek, it’s everybody understanding what’s going on here, because it’s about clinical quality and safety not just about a score.

Deb Rauch: I’m just going to share some of the tools that we list. I treat this every six months. It takes the specification manual and simplifies it into a high level description of what the measure is, what the numerator is from it, the denominator and all the exclusions. It’s intended to share with hospital leadership and nursing staff what the new measures are. You can see that these are things we’re working on right now there are plans for that in January.

This is the checklist that our nursing staff uses.

Jackie Popp: When I talked about combining your abstractor with your best Nike nurse or champion leader on the population, what they need to get started to be six months ahead would be that first data definition sheet. They sit down with that. The abstractor creates that they sit down and start thinking about workflow, how much is going to change here, how big a change is this and can we just slip it into the tools or do we have to create an education? What do we need to do about that?

That’s where the decision-making happens. I want to walk you through what it would look like just taking the VTE for medical patients, for example. What would preparing six months ahead look like? Like I said with this implementation team of the abstractor and leader/champion, they are asking those questions but planning backwards. At the bottom of the slide they’re saying how much of a change is this?

We know we need to get data to the staff by November/December if we’re going to be ready for January 1, 2013. Backing up from that it means that in October we have to make sure we have our abstraction so that we can give the report in November/December and then backing up from that we should be doing education in September and then repeat it in November with feedback.

That’s kind of how you’re planning to be six months ahead. That means you’re doing some guessing maybe. You’re grabbing some patients that make sense, maybe you don’t have full definitions on some of this work, but it gets you better than what you do if you’re just flipping the switch on January 1 and nobody knows what’s going on.

So really, six months ahead is the way we’ve done it. The big difference from what I’ve described to you is probably the abstractor involvement. I’m hearing from people that
they sometimes allow their abstractor to be in their house abstracting and they never really get out and some abstractors like that because they can hide a little bit and prefer that job.

Others have a different background and want to be part of the team. Think about how you’re assigning your abstractors. In our design the quality department has the abstractor not medical records. It brings them closer to the team of nurses who will be the change agents. Our conversations include anybody touching that patient.

Therefore our conversations are with physicians or any caregiver. Oftentimes physicians are calling Deb on the phone to get clarification on a metric. Or, they are calling with any other question to clarify wherever they are. So it’s a great resource.

The next best practice I can hand off to you is about how we do root cause in the moment, part of our design is to be abstracting the 15th of the month we have the data for the prior month. So we’re trying to give a fast turnaround time to our caregivers, to have conversations with them about a missed measure and we’ll show you how we do that.

There are actually two opportunities you want to be structured for and you probably are as well. You have the fix-it now—you find it in the moment when the patient isn’t gone yet. You have an opportunity. The other option is to fix-it next time or fix it later on the backend after the patient has been discharged. Maybe there’s a window of opportunity that’s something to add documentation that describes an exclusion. Both of those you want to have structures for and I’m going to talk about both separately.

The fix-it now is real time and again this is the value of your caregivers understanding at the bedside, what it’s all about, they know their tools and they’re accountable. We have charge nurses that are in a role which is 24/7. The charge nurses in a role to be checking and watching for missed measures, was it done?

When they do that and find one they don’t just fix it they really stand in the shoes of the nurse talking through what happened, what slipped through, what got by us and what do we need to fix so that doesn’t happen again? They’re problem solving in that moment, having a very rich conversation, so our charge nurses are ready for that and they do a great job.

It is the opportunity to grow your learning, so having that conversation with caregivers is very good. It’s the place to be with that. Oftentimes it is the call again to the abstractor. The charge nurse makes the call. The employee makes the call. They physician makes the call. You want to be able to have them access those abstractors. They have the information in their heads.

The second one is typically going to happen at the time of abstraction, we aren’t doing real time abstractions. It’s going to be the fix for the next time or it’s going to be just an opportunity that we can take care of just because we got lucky. We have started a very fast turnaround root cause process and this would be the one that I want to share with you and encourage you to try.

The abstractor again is abstracting the 15th about the prior month, so at the time they find a missed measure it starts with just that one event, and causes a root cause email to the person that’s the leader/champion. The leader/champion then is responsible to go investigate, have the conversation with the staff and physician, dig into it to understand it and again identify what caused it or how did it slip through.

Staff are crucial in helping us figure that out and helping us fix that, for whatever the cause is.
The leader/champion fills out the top portion and they're usually in their email responding in the ‘S’ bar, talking about what they found and later one what their action plan is and they've involved the director of the area in that decision-making.

Now I’m going to show you an example, how does that sound? On this page you’ll see the RCA email format it’s ‘S’ bar, so the top portion that says what went wrong, that’s being completed by the abstractor, so Deb will communicate in ‘S’ bar. She’ll communicate what measure it is and in this example it’s the immunization OB and this is an actual email that she recently did in July, picking out the patient identifiers.

So you’ll see in the ‘S’ bar situation background if that's meant in recommendation. You’ll see the recommendation does describe the specification. Again, the email is another opportunity to learn, so this is what the definition is based on. It’s that second portion investigation and immediate action that’s being completed by the leader/champion.

Now, Deb does it the day she finds the missed measures. The leader/champion takes care of it the day they find the missed measure that’s the difference. The turnaround time is today, so tomorrow when it happens we have it addressed. So it’s that quick turnaround that what I’m hearing from some of you is that it gets on a spreadsheet and it’s a once a month meeting. That might be the difference.

On that root cause, what we do with it is it then goes across all our clinical leaders. It’s an email that summarizes what was missed and what the action for correction is and it’s shared across our leadership group broadly, not just the people having assignment to the population and we all learn.

It also goes into a missed measure report which has names attached to it. It would have the physician’s name who is associated with the action or it will have the nursing area, because oftentimes it might have options for doing it today or tomorrow.

Now we’re going to step to number three. I wanted to talk a little about your highly effective teams. I want to challenge you a little bit on your teams. I know you all have them. I know you’re all working on improvement. I thought to give you an example about how you might think just a little further on your existing team’s and push them in their performance expectations just a bit.

If you take for example, your outpatient 23 head CT and imaging, if you think in terms of just that, if you have your improvement team… most improvement teams would sit down and deal with that by saying let’s identify our patients. If we can identify our patients and know who they are when they come in the door, than we have a leg up. So they map it all out into a flow chart and figure out our patients either wheeled in the door or walk in. This is how we’re going to deal with that to identify them quickly so we aren’t wasting time.

Your team might also go further and say let’s shorten up the time in getting them to the test. How can we affect that? They might… let’s think outside the box we’re wasting time here, they’re on a gurney and they come to us on a gurney so why not just leave them on the gurney and take them down to imaging to get that test done? That’s probably what your teams are doing now.

The push further goes to that next level goes to that next level that I have on the slide. We have great opportunity to make a difference in that there’s so many of us that share that same performance measure, so my example goes to… in our case we have remote radiologists. It’s not about the radiologist in the facility but the one that’s not in our facility somebody else’s facility and not even a part of our care system even.

So we’re trying to affect them on evenings, nights, holidays because we want their turnaround time to change.
With CMS and core measures we have the same opportunity. We know it’s a national priority and we can present it that way. We can present our data on turnaround and by talking with the radiologist leader, he was very engaged in that and knowing it was a shared performance metric. He was at the table and he was talking with us about how we could standardize how the physician enters into the system or when the physician enters into the system so it drops and becomes visible and gets time stamped.

That’s the challenge I have. We’re used to stopping but you can go further with some of these measures because we have that in common. Of course, then going a little further than that, we’re part of Epic, so once we get radiant on there we have a system solution so it’s no longer the issue for individual practice of when they write their notes.

So push your teams a little bit. See if you can push them beyond what they've been stopping at.

The most important thing I could pass on to you about being successful probably is about the accountability for Deb and for the champion/leader. Both have performance goals about this work. They have on their annual performance a score to meet on CMS and core measures, so they have skin in the game. They aren’t the nurse taking care of the patient but they have skin in the game and that is a performance metric for them both.

The leader/champion is called to our quality committee. We have a dashboard, a scorecard that’s talking about where we are. We look at it monthly. We color code it red/green/yellow. When it’s red it’s all about managing our reds. That leader/champion is at that meeting on that agenda having that conversation about why we’re red. What are the issues? What is the progress? What can we do to help you as leaders? So it’s diving down into those and it’s all about immunization or about antibiotic.

The alignment of our best talent, again maximizing that abstractor talent and partnering them in the right partnership with those it can affect. A change from the definition to action is essential and then engaging the caregivers. They are very creative and resourceful and know they have ideals of what needs to change to make it successful.

The last one I would pass on to you would be about every case counts. Again, the Harvard example, in that if we’re going to be Harvard then we’re small we can’t fail once, if we fail once and our percentages are awful, so every case counts and every missed measure is a miss we want to chase down and figure out.

Actually, on some of the new measures there might be three misses that you can cluster and it’s all about the same solution; however, you do it you can tackle those. The trick to tackling them again is that turnaround time, make it fresh so the caregivers can have a rich conversation, but it’s also about accountability so we’re going talk a little more about that in our fourth point.

Everybody wants to make a difference in healthcare from the heart. They want to improve quality. They want to improve patient experience. They want to make it safer for patients, but not every one of the caregivers shows up with that today. We have nurses who show up, put in their 8 hours, get their paycheck and go home and I would bet you do as well.

So in order to engage all those people you really have to give them a performance metric, so your annual performance is about this score. We do that from the executive to the director to the staff, and the physician as well. Our clinical committees have a score. It's all been everyone having skin in the game for that score. It's cascading so our president... we found a funky mass that makes it roll up in to one measure. So we have all our inpatient and outpatient CMS core measures with funky mass. If you want to know funky mass I made it up. We have it all rolled up into one and set for the year so our executives are trying to meet a target.
It’s a five point scale that targets. Its number three, you can be below target or really below target or you can be a four and five above or really quiet exceptional. We want to give opportunity for exceptional performance in setting that goal.

Cascading means there’s a piece or chunk of that goal that trickles down through the director/supervisor staff. That shared goal puts everybody in the game trying to make the difference, trying to get target. So committees have dashboards, people might have scorecards, we might be talking tactics, what’s your goal and tactics for the quarter? Those are your 90 day plans.

Next is an example of that cascading. Again the president/VP, having all CMS rolled up. You can bet they’re looking at their value-based purchasing scores but that isn’t the only scores they’re looking at. The directors/supervisors, we might have some of them have the whole roll-up if they’re doing well and in maintenance but we’ll also isolate out the ones that are brand new.

ED happens to be one of those. They have inpatient/outpatient but it’s rolled up and specific to what they can affect. We have had both, that we roll up and it’s shared broader than their area, so Med Cert has a stake in surgery’s success. They might share the tail end of that patient, but they share in the overall roll-up metric, so both have to work together to succeed.

We have then employees that the director can choose. This immunization is most at risk so I’m going to assign that to my staff or they can do several of those or a roll-up of those, it’s somewhat their choice in how they want to leverage because they need to succeed, it’s all cascading.

This data then is also, besides annual reviews, we have a missed measure report that’s looked at for patterns and trends. We’re also putting names on that so it feeds into our ongoing professional practice evaluation for our physicians and leadership development. Take advantage of the opportunities you have in this work for development. If you have a problem in any one of your measures you’re pulling that developing leader into it to give them an opportunity. Lots of twofers and threefers here.

That’s what I have to share with you and Deb and I are willing to share whatever we have because we want you to be successful in whatever way that fits you. There might be one piece that fits you, I’ll be happy if there’s one piece but if you have any questions or you want us to share anything, please contact us we’re very generous.

Thank you so much. Are there any questions?

**Guest:** How does Northland combine with Fairview or be separate from Fairview in how we approach this work.

**Jackie:** Right now Epic is our electronic record and I thought that would give us all the answers and so did everyone else but it doesn’t have a darn answer in it I don’t think. I thought it would be the algorithm that would identify our patients, helping our physicians but no. I thought it would be the red flag alert that would pop in our faces and be the solution, but no.

The best we’ve come up with is the checklist at discharge, you can take advantage of that and maybe cue pharmacy to take a last look at it to see if they see anything or you have your auditors sets off beyond the floor looking and checking. We had thoughts about the possibilities of doing it as a care system because of the electronic record. It didn’t happen, too complex.

We had started this as separate hospitals because the university is about 50% of Fairview. Northland the little dot, we are the tiniest dot of the group and what do we have in common? There are complexities we don’t have in common.
Even the design of our abstractors we played with. Some of Fairview has abstractors reporting to medical records. Some have some reporting to quality. How we put our teams together is different. You could look at that and say well, that’s a bunch of test plots and we should come out with answers soon. We haven’t come up with that either.

The thing I would advocate is that the closer you are to the bedside in what you’re analyzing and troubleshooting the better off you are, because the differences with those caregivers is they have the information you need to know to make a difference. The closer you are with abstraction the better and more effective you’re going to be.

Another question that came up was meaningful use, how it has helped or not helped. I don’t put a lot of stock into meaningful use at this point and I know we’re going into phase two of that. I really think the care that we’re designing is safe care, best care and meaningful use will just tag onto that. It’s not about our electronics as much as it is about delivering the care.

Therefore, we need to make epic or meaningful use work for us to deliver safe and best care. I think if we’re heading in that direction we don’t have to worry about meaningful use.

Guest: 36:00 inaudible

Deb Rauch: I run a report based on 36:15 when I run it. Not daily but once a week. We’ve been doing stroke for close to a year now because before they were required they were joint commission measures before, so we knew they would be required eventually so we had the opportunity to pull it into our process early and we’ve been doing that routinely.

Jackie Popp: If measures are coming up in another place oftentimes we’ll tag onto it if we have a confidence level that eventually it’s going to be CMS. Just like ZBI (zero birth injury) oh come to find out it’s coming up as one of your OB measures. So you can see patterns and trends of what’s coming up. If they have you doing a time stamp metric don’t you think it’s eventually going to come into an expectation?

Some of it is a little guesswork but it’s comparing across what’s at some of those other test measure websites.

Guest: How common or different are you?

Deb Rauch: We’re working now on establishing our baseline data by looking at July discharges. It’s all in the annual, using a paper abstract right now until we get things set up with our vendor and then I’m manually calculating a rough guess so we can show leadership to get the conversations started.

Jackie Popp: You can pick small samples. You can pick larger samples whatever you want we just encourage you to get it started before going live on January 1. This is in our Fairview partners, so its interesting you would ask that, there’s still a cultural mindset of it’s really all about the abstractor and the abstractor doesn’t have to submit it until this date, so that’s our date not the date the performance at the bedside needs to be scored.

Our minds have to shift just for that to even be six months ahead of that shift. We’re thinking in the wrong place if we’re when we have to submit it, it’s when we actually deliver it because it’s all about safety and quality care.

Guest: What vendor do you use?

Jackie Popp: Premier. That is a cross care vendor we use. I thank you so much for letting us talk to you. If you have any other questions or want any of this material shared, contact us, our email and other information are available.
Deb Rauch: Thank you.