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Thinking Upstream: Proactive Empowerment Resources for Quality Professionals

Welcome!

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President/CEO

Agenda

- **7:30 - 8:30 AM** Registration and Breakfast
- **8:30 - 8:45 AM** Welcome and Opening Remarks – Mary Conti, WAHQ President
- **8:45 - 10:45 AM** Keynote – Knowledge is Power – Using Quality Tools to Increase Resilience and Empowerment – Therese Dodd BA, MBA, RN, CPHQ, FNAHQ, FACT Consulting Services
- **10:45 – 11:00 AM** Break, Vendors, and Storyboard Passport
- **11:00 – Noon** A Review of Analytical Tools and Data Governance, Literacy and Integrity, and Association to Quality Improvement –Kate Konitzer and Becky Birchmeier, Aspirus Health
- **Noon - 12:30 PM** Utilizing the Electronic Health Record (EHR) to Translate Information to Improve Outcomes – Mary Conti – Froedtert Health
- **12:30 – 1:30 PM** Lunch, Vendors, and Storyboard Passport
- **1:30 – 2:15 PM** Population Care Management, Transitional Care Management (TCM) & Return on Investment (ROI) – Laura Wieloch – Advocate Aurora 2:15 – 3:15 PM Self-Management Strategies/Motivational Interviewing – Cynthia Kollauf – Advocate Aurora
- **3:15 – 3:30 PM** Break, Vendors, and Storyboard Passport
- **3:30 – 4:15 PM** WHA Legislative and Quality Updates – Matthew Stanford and Jill Lindwall – Wisconsin Hospital Association
- **4:15 – 4:30 PM** Closing Remarks – Door Prize

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MANY thanks!

Becky Steward
Conference Coordinator

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Many thanks to our vendors and affiliates for their support:

- American Heart Association (AHA)
- Barostim
- CardioMEMS
- Lilly
- Moderna
- Wisconsin Collaborative for Healthcare Quality (WCHQ)
- Wisconsin Hospital Association (WHA)

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- Vendor and storyboard passports
- Food service and beverage stations
- Restrooms
- SLIDO app (slido.com)
- Evaluations and CE certificate

- WAHQ Membership
  - Newsletter
- Board of Directors
  - See storyboard – we're recruiting!
  - Conference registration

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Knowledge is Power – Using Quality Tools to Increase Resilience and Empowerment

Therese (Tracy) Dodd, BA, MBA, RN, CPHQ, FNAHQ
Senior Consultant - Quality Improvement &
Accreditation/Regulatory Compliance

Conflict of Interest Statement

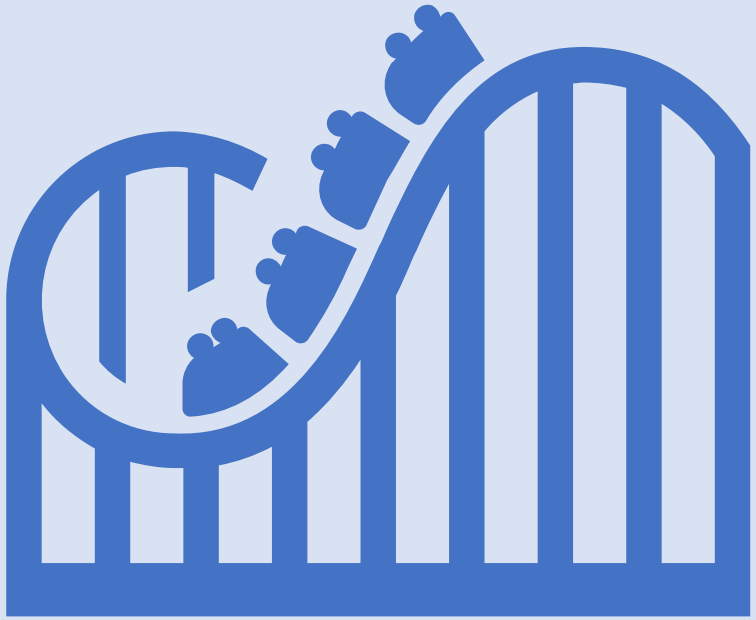
I confirm that neither I nor any of my relatives nor any business with which I am associated have any personal or business interest in or potential for personal gain from any of the organizations or projects linked to this presentation.

Objectives

At the conclusion of this presentation, the attendee will:

- Appreciate how professional resiliency factors into work performance
- Be able to list at least 3 factors that influence professional resiliency
- Be able to list at least 3 approaches to increase professional resiliency and self-empowerment

Overview of Need for Resilience & Empowerment



Change is constant and can be stressful.

Stress that's left unchecked can contribute to many health problems, such as high blood pressure, heart disease, obesity, and diabetes.

An individual’s resiliency, the ability to rebound or recover from stress, is self-empowering.

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Are you resilient?

Some resilience measures assess resources that may promote resilience rather than recovery, resistance, adaptation, or thriving.

The brief resilience scale (BRS) assesses one's ability to bounce back or recover from stress.

- Predictably related to personal characteristics, social relations, coping, and health in all samples.
- Negatively related to anxiety, depression, negative affect, and physical symptoms when other resilience measures and optimism, social support, and "Type D" personality (high negative affect and high social inhibition) were controlled.

Brief Resiliency Scale (BRS)

The BRS is a reliable means for measuring resilience as the ability to rebound from stress and may provide valuable information about people who are coping with health-related and other stressors.

How resilient are you?

Please respond to each item by marking one box per row		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
BRS 1	I tend to bounce back quickly after hard times	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 2	I have a hard time making it through stressful events.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 3	It does not take me long to recover from a stressful event.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 4	It is hard for me to snap back when something bad happens.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
BRS 5	I usually come through difficult times with little trouble.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
BRS 6	I tend to take a long time to get over set-backs in my life.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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Brief Resiliency Scale (BRS) - SCORING

1. Add the responses varying from 1-5 for all six items giving a range from 6-30.

2. Divide the total sum by the total number of questions answered.

Score: Total for All Items/6

Brief Resiliency Scale (BRS) – GROUP SCORING

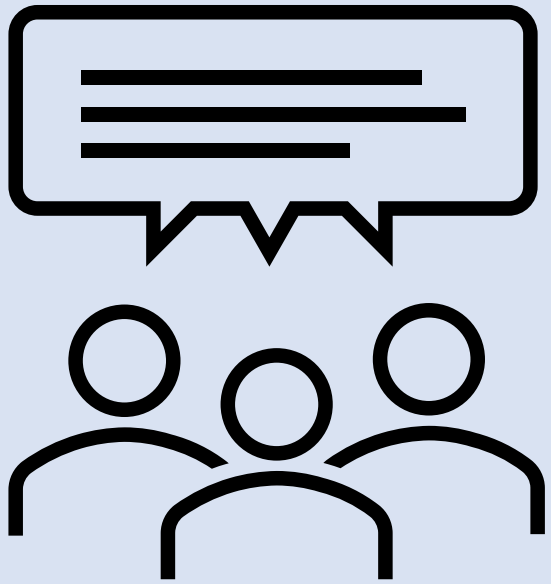
POLLING QUESTION 1: Select the appropriate range for your Brief Resiliency Scale (BRS) score below.

- 1 - 1.99
- 2 - 2.99
- 3 - 3.99
- 4 - 4.30
- 4.31 - 5

https://app.sli.do/event/1k3sQXkkjA43AsHrczEGxB

Brief Resiliency Scale (BRS) – BENCHMARKS & GROUP DISCUSSION

1.00-2.99	**Low resilience**
3.00-4.30	Normal resilience
4.31-5.00	High resilience



Critical Resources for Bouncing Back/Thriving

Smith et al assessments included personal and social resources active coping, mindfulness, mood clarity, optimism, purpose in life, spirituality, positive relations with others, and social support. The demographic characteristics assessed included age, gender, education, and income.

- Correlations with greater resilience revealed:
  1. Mindfulness, mood clarity, purpose in life, optimism, and active coping
  2. Age and male gender also relate to greater resilience

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Significant Findings from Surveys of Transplant and Cellular Therapy (TCT) Quality Professionals

Methods

- Targeted respondents
- Online survey

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Work Resilience and Effectiveness in Contributing to Program Success

- 75% of respondents agreed that improved resilience promotes increased productivity.
- Survey results revealed links between lower BRS scores, longer work weeks, and failure to use earned vacation time. Quality Managers (QMs) who reported they did not take their vacation leave had statistically significant lower BRS scores.

1. Analysis of this subgroup of respondents showed they routinely work >40 hours/week, and a majority were not engaged in managing their workload which was a measure shown to result in a lower BRS score.
2. Although not reflected in lower BRS scores, respondents reported they did not engage in regular 1-to-1 meetings with their direct manager or program director, and missed opportunities to discuss workload management.

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Work Resilience and Effectiveness in Contributing to Program Success

Approaches for improvement - self-advocate to optimize time management, productivity, and communication; e.g.,

- Proactively plan workload management with program leadership
- Streamline work flows
- Develop “ready” references and job aids
- Prioritize “to do” lists.

Increasing work resiliency through open communication and building trust with program and organizational leaders

1. Respondents who reported trust in their senior directors and executives had statistically significant higher mean BRS score

2. While not reflected by lower BRS score, a proportionally high number of QMs reported that they did not engage in regular 1-to-1 meetings with their direct manager, program director, or organization's quality department

Increasing work resiliency through open communication and building trust with program and organizational leaders

Approaches for improvement:

- Proactively schedule structured interactions with leaders; e.g., SWOT analysis for role and program

Internal	**Strengths**	**Weaknesses**
External	**Opportunities**	**Threats**

Bringing together the quality community to promote process effectiveness and better outcomes

Metanalysis results of networking opportunities based on BRS scores <3 and 3-5 related to:

1. Audits
2. Deviations management
3. Document control
4. Organizational charts
5. Outcome analysis
6. Quality management principles and tools

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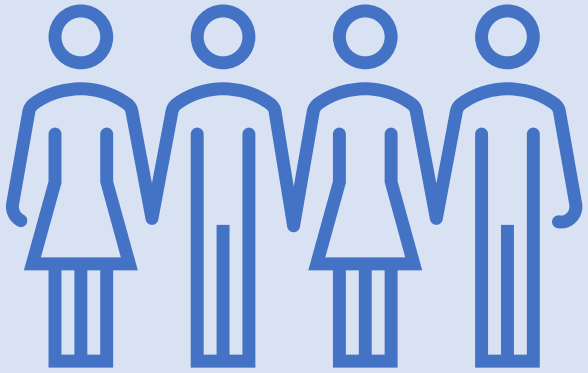
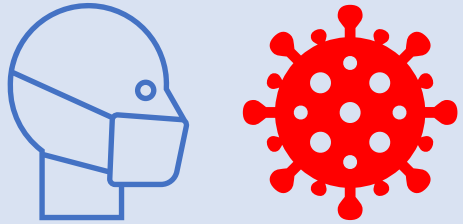
Bringing together the quality community to promote process effectiveness and better outcomes

Approaches for improvement

1. Actively engage in networking opportunities, e.g., WAHQ Board of Directors, LinkedIn
2. Seek out self-development resources, e.g., quality “links” in WAHQ newsletter



Quality Manager perspectives on resiliency during the COVID 19 pandemic



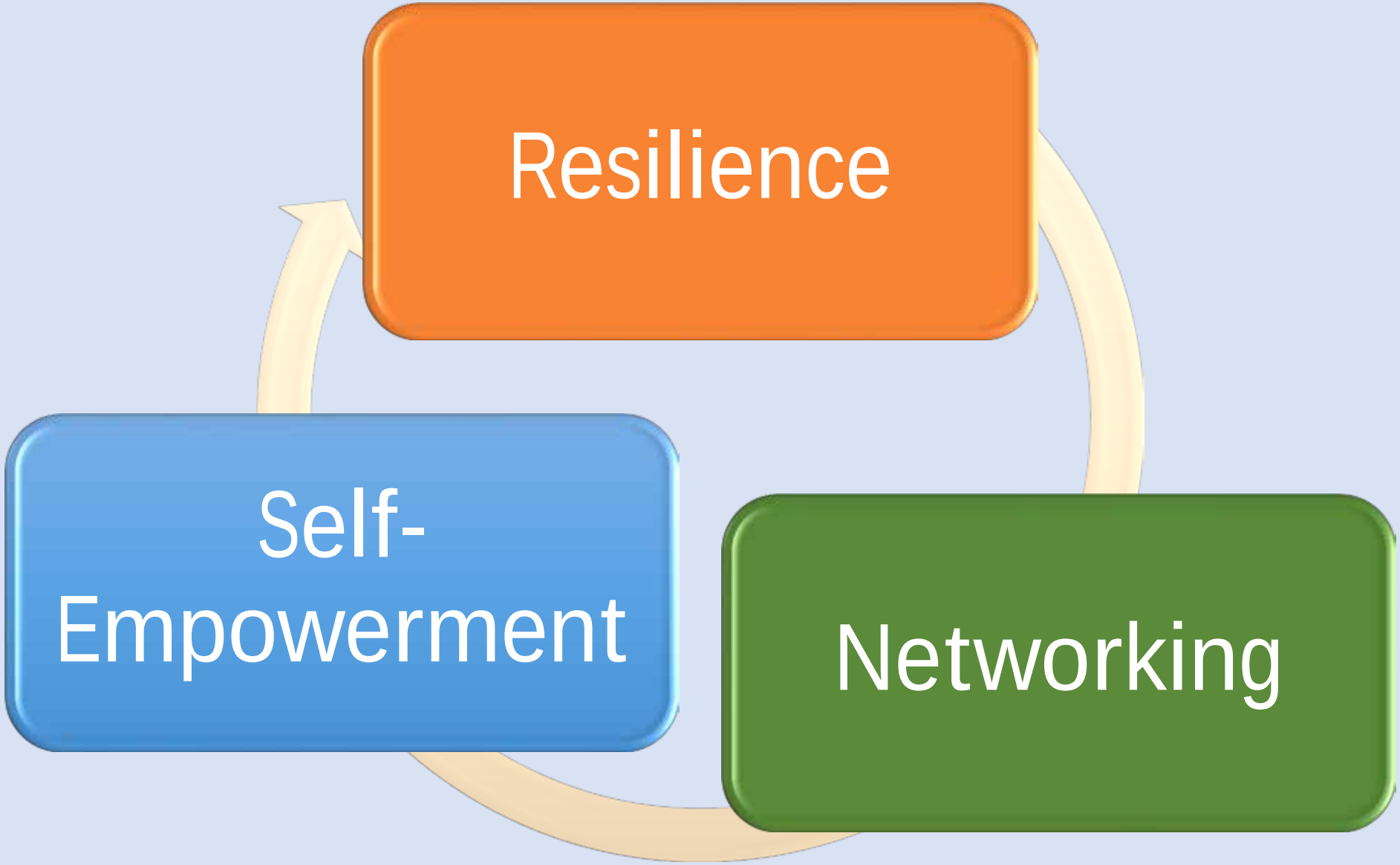
- The mean BRS score for the respondents of the follow-up survey in 2020 was lower than the first survey in 2016 however, the minimum BRS score in 2020 was higher.
- Operational elements associated with communication, support, and trust in program leaders were again identified as key elements that strongly

Introduce next BRS scores when analyzed against the time at which surveys were submitted.

Quality Manager perspectives on resiliency during the COVID 19 pandemic

Approaches for improvement

- Prepare for the unexpected…


Resilience
Networking
Self-
Empowerment

Looking Forward

WAHQ Annual Conference topics will provide substance and resources to empower QMs and support resiliency

Additional References and Resources

Wisconsin Association for Healthcare Quality https://www.wahq.org/

- Events
- Grants
- LinkedIn
- Member Portal
- Newsletter

Additional References and Resources – cont'd.

- Dodd, T et al. (2018). *Increasing Work Resilience of the Quality Manager (QM) in Order to Improve Their Effectiveness in Contributing to Program Success.* Biology of Blood and Marrow Transplantation. 24. S486-S487. 10.1016/j.bbmt.2017.12.806.
- Dodd, T et al. (2019*). Improving Quality Manager (QM) Workload Management in Order to Increase Their Resiliency and Effectiveness in Contributing to Program Success. Biology of Blood and Marrow Transplantation.* 25. S420-S421. 10.1016/j.bbmt.2018.12.631.
- Dodd, T et al. (2021). *Resiliency during a COVID 19 Pandemic: The Quality Manager Perspective. Transplantation and Cellular Therapy. 27*. S439-S441. 10.1016/S2666-6367(21)00568-6.
- Dodd, T et al. (2017). *Meta-Planning Between the Foundation for the Accreditation of Cellular Therapy and American Society for Blood and Marrow Transplantation to Promote Quality Improvement Across Transplant Programs.* Biology of Blood and Marrow Transplantation. 23. S448. 10.1016/j.bbmt.2016.12.528.
- Rosati, C et al. (2017). *Common Themes Identified By Bringing Together the BMT Quality Community to Promote Process and Outcomes Improvement. Biology of Blood and Marrow Transplantation.* 23. S450-S451. 10.1016/j.bbmt.2016.12.534.
- Rosati, C et al. (2019). *Improving Quality Manager (QM) Resiliency with Open Communication and Trust between the QM and Program and Organizational Leaders.* Biology of Blood and Marrow Transplantation. 25. S419-S420. 10.1016/j.bbmt.2018.12.630.

Additional References and Resources – cont'd.

- Rodríguez-Rey R, Alonso-Tapia J., & Hernansaiz-Garrido H. Reliability and validity of the Brief Resilience Scale (BRS) Spanish Version. Psychol Assess. 2016 May;28(5):e101-e110. doi: 10.1037/pas0000191. Epub 2015 Oct 26. PMID: 26502199.
- Smith B.W., Dalen J., Wiggins K., Tooley E., Christopher P., & Bernard J. The brief resilience scale: assessing the ability to bounce back. Int J Behav Med. 2008;15(3):194-200. doi: 10.1080/10705500802222972. PMID: 18696313.
- Smith, B.W., Epstein, E.E., Oritz, J.A., Christopher, P.K., & Tooley, E.M. (2013). The Foundations of Resilience: What are the critical resources for bouncing back from stress? In Prince-Embury, S. & Saklofske, D.H. (Eds.), Resilience in children, adolescents, and adults: Translating research into practice, The Springer series on human exceptionality (pp. 167-187). New York, NY: Springer.

Questions?

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Thank you!

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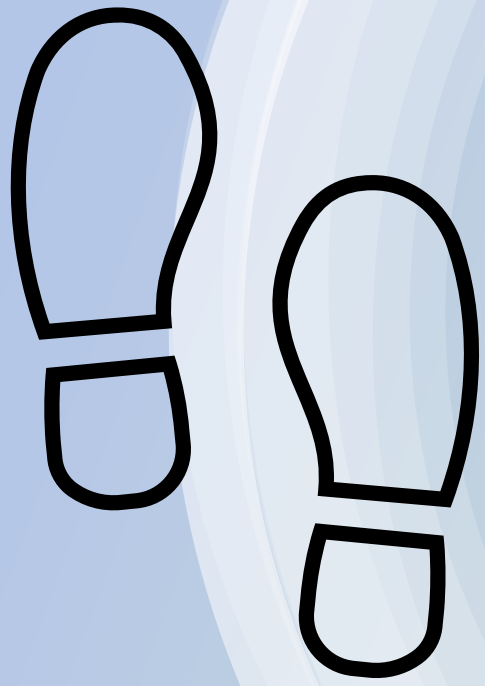

Break

Vendors & Storyboards Passport

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Quality Data. Quality Care.

A review of data association to quality care and improvement, analytical tools, and data governance, literacy and integrity

Kate Konitzer, MS-Medical Informatics

Becky Birchmeier, MS-Nursing, RN, CPHQ, Aspirus Health

Conflict of Interest Statement

I confirm that neither I nor any of my relatives nor any business with which I am associated have any personal or business interest in or potential for personal gain from any of the organizations or projects linked to this presentation.

Objectives

At the conclusion of this presentation, the attendee will:

- Understand the quality of data as it relates to quality of care
- Develop partnerships with your stakeholders
- Establish and apply components of data quality
- Measure outcomes you want to achieve

Quality Data. Quality Care.

Accurately represent the care provided to the patients served.

Why is this important?

Patient Care Value: How does quality of data relate to quality of care?

- Continuity of care and interoperability
- Primary prevention (identify risks)
- Secondary prevention (early detection)
- Tertiary prevention (mitigate complications)
- Proactive and reactive intervention
- Leading/Lagging; Process/Outcome; Cause/Effect
  - Leading measures (how likely a goal will be achieved)
  - Lagging measures (have we achieved the goal)

- Identify gaps in care
- Clinical decision support at point of care
- Patient safety
- Identify patient risks (drug-drug, opioid MME, medical recalls, drug safety alert)
- Innovations/research/advancements in care (e.g., pharmacogenetics)
- Patient awareness/engagement (e.g., portal, open notes/CURES Act)
- System trends/opportunities (e.g., care for patients with DM)
- State/national trends/opportunities (e.g., new communicable disease-COVID)

Operational/Administrative Value: How does quality of data relate to quality of care?

- System trends/opportunities (e.g., resource/ service gaps)
- Patient experience
- Staff satisfaction/engagement/ assessment of culture
- Access/wait times
- No shows
- Volumes
- Population factors

- Revenue Cycle
- Payors/denials
- Staffing and resource decisions
- Costs (formulary, supplies)
- Equipment utilization

Who is paying attention to data ?

- Patient
- Care team
- Workforce leadership
- Executive leadership
- Community
- State/Federal
- Third party payors
- Accrediting bodies

Gaps in data

Data availability

- Is the data codified (paper charting, non-codified fields)
- Data mapping (different fields, awareness of configurations)
- EHR configurations (‘organization-sized’ EHR, if you have seen one version, you have seen one version)
- Configuration in silos
- Not collecting data (e.g., documenting processes)

Inaccurate data

- Units of measure (lb/kg)
- Not accurately assessing data
- Wrong patient
- Unintended consequences of interfaced data

Quality Implications

Lack of data → Uninformed/underinformed care and decisions

Inaccurate data → Poor care and unfounded decisions

Facts [Patient safety (who.int)]

- Patient harm is the 14th leading cause of the global disease burden, comparable to diseases such as tuberculosis and malaria
- While in the hospital, 1 in 10 patients are harmed
- Unsafe use of medication harms millions and costs billions of dollars annually
- 15% of health spending is wasted dealing with all aspects of adverse events
- Investments in reducing patient safety incidents can lead to significant financial savings
- Hospital infections affect 14 out of every 100 patients admitted
- More than 1 million patients die annually from surgical complications
- Inaccurate or delayed diagnoses affect all settings of care and harm an unacceptable number of patients
- While the use of radiation has improved health care, overall medical exposure to radiation is a public health and safety concern
- Administrative errors account for up to half of all medical errors in primary care

Assessing your Organization's Data and Safety Culture

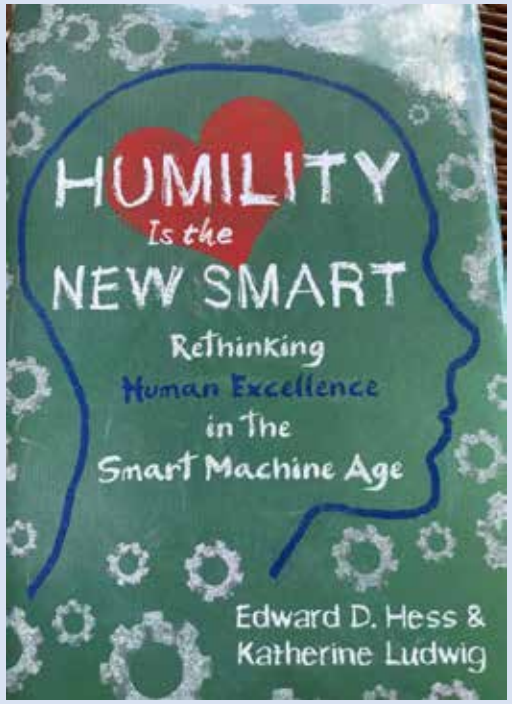
- Just Culture/culture of safety
- Audit consistency of documentation
- Audit reporting/near misses
- Assess how the organization is using data in a new data-rich environment
- Response to reporting

Culture Shift

When quality is first, all else follows

Change your mental model from fix quality problems to fully understand quality problems

Recommend à



Develop Your Partnerships


Operations


Patient Care


Quality


Analytics


IT


Finance


Marketing


Other

Creating a learning organization!

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Technology à Data

It is predicted that by 2025 healthcare would be the fastest growing source of data worldwide. The healthcare industry currently generates 30% of the world's data volume.

Data Quality Impacts Quality of Care

- Use Case
- Root Cause Analysis
- Process Improvement

How does the data help us?

Data will give us insights

- Must be recorded accurately
- Workflows must support the collection of the data
- Technology must facilitate the accurate collection of the data and support the workflows
- Must be an understanding of how that data is used across the organization

Data Quality Characteristics

- Accuracy: Information is correct.
- Completeness: Information is comprehensive.
- Reliability: Information doesn’t contradict another piece of information in a different source or system.
- Relevance: Information is useful.
- Timeliness: Information is up-to-date.

Data Literacy

Data literacy is really about digital transformation

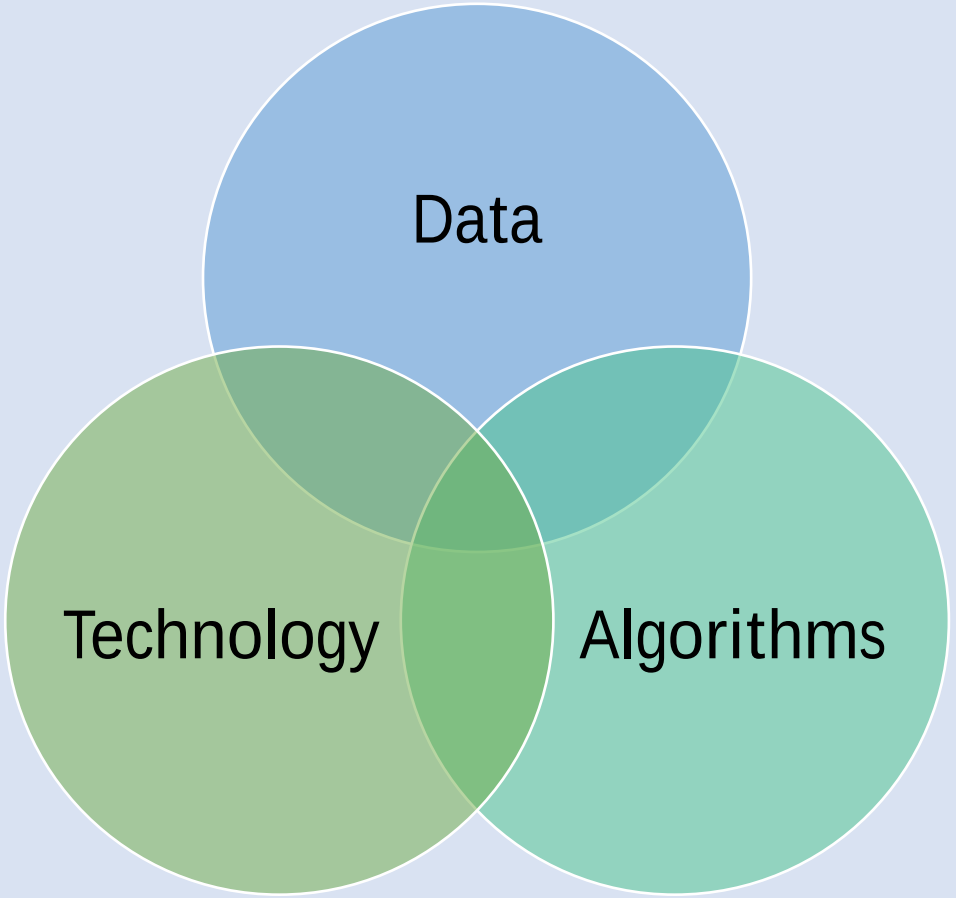
We must change the way organizations use and think about data

The data can provide us with so many insights, there is always a story to be told

We need to learn how to use the data for strategic initiatives, taking care of patients, and taking care of employees, our colleauges, the population of patients served

Data is insights

Digital Transformation



[The Digital Mindset, Part 1 of 2 - Brené Brown (brenebrown.com)]

Data Literacy Definition

The ability to read, write and communicate data in context — with an understanding of the data sources and constructs, analytical methods and techniques applied — and the ability to describe the use-case application and resulting business value or outcome.

Definition of Data Literacy - Gartner Information Technology Glossary

Apply Data Literacy to our Use Case

Data - Inputs

Stories - Outputs

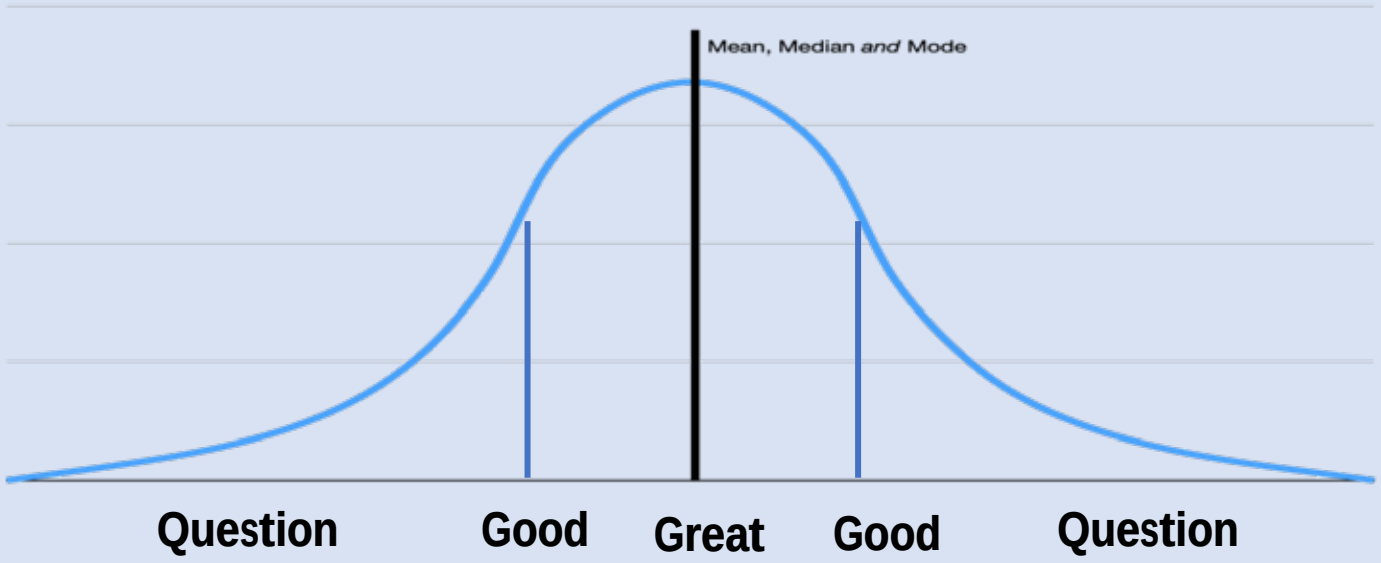
Data Governance

A discipline, a practice adopted by your organization

An organized state that governs all things around data

- Policies
- Security
- Definitions
- Measures accuracy, consistency, relevance and timeliness of data

Data Profiling



Measure Outcomes you want to Achieve

Use Case – Reduce Opioid Usage in Practice

The opioid epidemic is a national crisis. The objectives of this report were to describe prescription opioid use in Wisconsin from 2008–2016 using unique population representative data and to assess which demographic, health, and behavioral health characteristics were related to past 30-day prescribed opioid use.

WMJ. 2020 Jun; 119(2): 102–109.

Downstream impacts

How else will this data be used?

Who might be consumers of this data?

How can this be used in population health studies?

Who is impacted if I make changes to my workflow, how I record this information, change processes?

Advancing Data Quality

- Use the technology across your System to facilitate best practices
- Profile your data to look for opportunities to improve
- Advance data literacy across the organization to create that Learning Organization
  - Facilitate Lunch and Learn sessions
  - Include data and analytics in your orientation
  - Host management series sessions
  - Attend department meetings
  - Include critical thinking, curiosity, data and analytics in your job descriptions
- Establish a data governance framework and implement those best practices

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Additional References and Resources

- The Digital Mindset, Part 1 of 2 - Brené Brown (brenebrown.com)
- The Digital Mindset, Part 2 of 2 - Brené Brown (brenebrown.com)
- "*Developing a Digital Mindset: How to Lead Your Organization Into the Age of Data, Algorithms, and AI*," by Tsedal Neeley and Paul Leonardi in *Harvard Business Review*
- *"Humility is the New Smart Rethinking Human Excellence in the Smart Machine Age"* by Edward D. Hess and Katherine Ludwig

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Questions?

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Thank you!

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Utilizing the EHR to Translate Information to Improve Outcomes

Mary Conti, RN, BSN, SSLBBHC

RN Clinical Program Manager, Froedtert Health

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Froedtert & Medical College of Wisconsin

Froedtert Hospital

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2023 **Fact Sheet**

Vital Statistics

As of June 30, 2022

Beds	Emergency Visits	Patient Admissions	Outpatient Visits
711	72,520	37,149	948,203

Physicians	Nurses	Staff	Patient Days of Care
1,713	2,548	7,753	225,594

Average Length of Stay (Days)	6.02
Average Daily Census	618.07
Cancer Registry Cases	6,121
Cardiology Encounters	70,874
Live Births	3,418
Patient Transfers from Other Facilities	13,620
Surgeries	
Inpatient	11,314
Outpatient	13,894
Transplants	
• Blood and Marrow	374
• Heart	23
• Kidney	65
• Liver	14
• Pancreas	2
Trauma Center Patients Evaluated	4,095

Vision

We will be the trusted leader by transforming health care and connecting communities to the best of academic medicine.

Mission

We advance the health of the people of the diverse communities we serve through exceptional care enhanced by innovation and discovery.

Values

Value People. We treat others with respect, knowing that their feelings, thoughts and experiences are as important as our own.

Work Together. We collaborate across the enterprise to put forward our best.

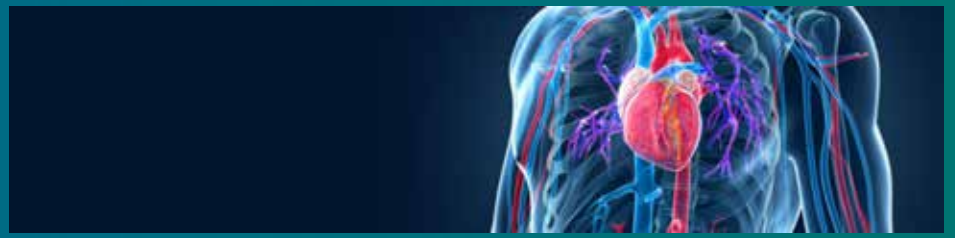
Act Now. We take action to solve problems and move forward quickly.

Own It. We take full accountability for our decisions, actions and results.

Break Through. We change the future of care with creativity and innovation.

Deliver Excellence. We set the standard that others aspire to by always asking "What more can we do?"

Froedtert Health Wisconsin Locations



- Milwaukee – Large Academic Medical Center
- Menomonee Falls-Community Hospital
- West Bend-Community Hospital
- Manitowoc – NEW-Community Hospital

Froedtert & Medical College of Wisconsin

Objectives

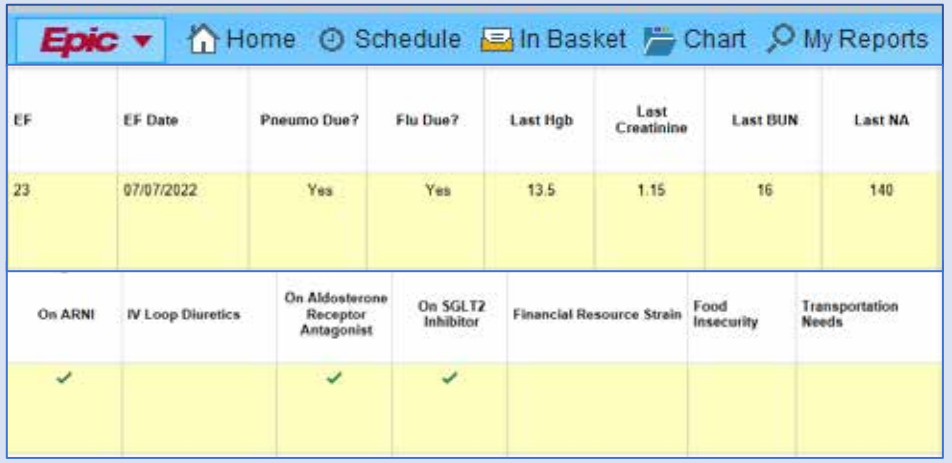
At the conclusion of this presentation:

- Participants will be able to identify examples of EHR tools that are used to drive improved processes and patient outcomes
- Participants will be able to identify ways in which to improve quality targets

EHR Tool Used to Drive Processes & Outcomes

Tool : EHR-EPIC Real-Time Reporting Workbench Daily Heart Failure patient report

Includes Demographics/Inpatient team(s)
Ejection Fraction
Guideline Directed Medical Therapy
Labs
Care Plan documented
Key past medical history/SDOH
Estimated Date of Discharge



Daily Process: Heart Failure RN Coordinator Role

- Two RN Coordinators at the Academic Medical Center/FMF Community Hospital
- Reviews daily report (M-F) to identify GDMT opportunities
- Provides inpatient list for Advanced HF APNP consult or
- Pages FMF inpatient team with GDMT recommendations
- Identifies Patient education opportunities

Meets with patient to coordinate 7 day follow up appointment
Identifies potential VAD/TRP and Amyloid patients
RN frontline staff provide scales & standardized patient education to the patient

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EPIC Reporting Workbench – Retrospective Report Tracking Transitions of Care Metrics

- Inpatient seven day follow up or established clinic appointment
- Outpatient Pharmacist reviews an EPIC HF Outpatient/Registry report to identify patients/providers
- Providers sign a Collaborative Practice agreement for patients to be optimized on GDMT
- Patients are outreached by phone and in-person as necessary
- Pre-Auth medications and enrolls patients in drug savings program

ØCarry your process metrics across the continuum to achieve the best patient outcomes

ØJoin your quality team to focus on processes to improve the patient outcomes

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Benchmarking and Reporting Quality Targets

- Using Evidence based benchmarking allows standard definitions and comparison performance creates clear targets
- Enrolling in National Registries like the American Heart Association, Vizient, NCDR, Magnet and others allows population outcome comparisons
- Identify your patient population targets and measure performance using internal EHR inpatient and outpatient information
- Utilize internal Quality Resources to request data and request trending reports to evaluate target success
- Your EHR is filled with valuable information for the care givers

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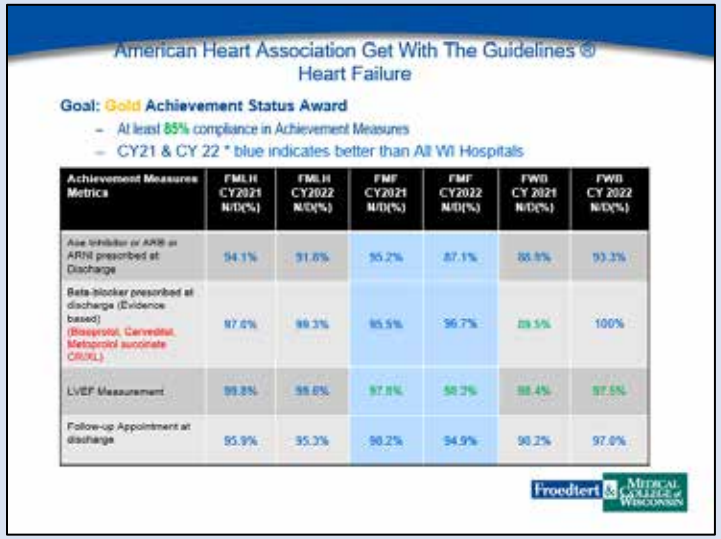
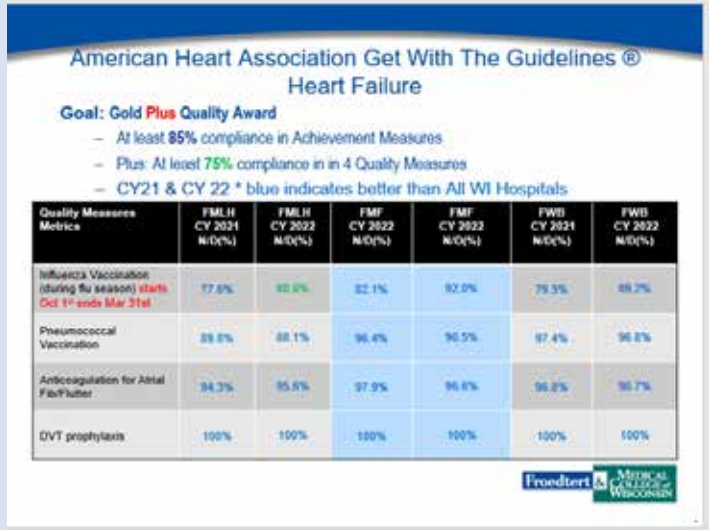
Tracking & Reporting Comparative Outcomes Using the Get With The Guidelines HF Registry


American Heart Association Get With The Guidelines ®
Heart Failure

Goal: Gold Achievement Status Award

- At least 85% compliance in Achievement Measures
- CY21 & CY 22 * blue indicates better than All WI Hospitals

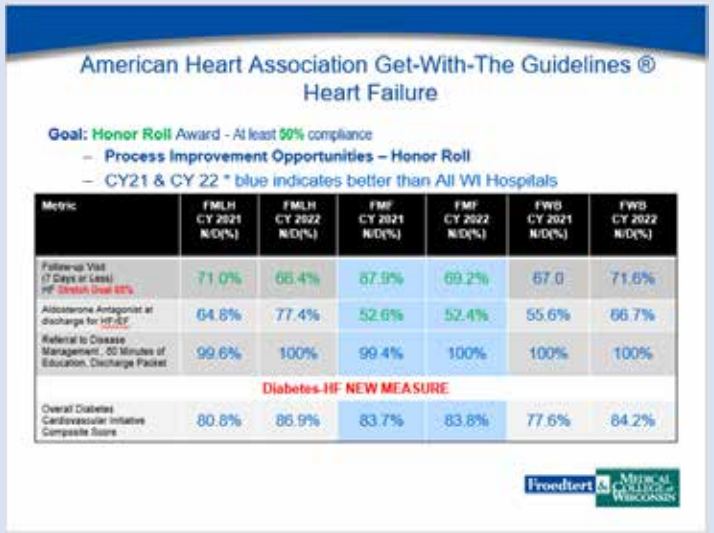
Achievement Measures Metrics	FMLH CY2021 N/D(%)	FMLH CY2022 N/D(%)	FMF CY2021 N/D(%)	FMF CY2022 N/D(%)	FWB CY 2021 N/D(%)	FWB CY 2022 N/D(%)
Ace Inhibitor or ARB or ARNI prescribed at Discharge	94.1%	91.6%	95.2%	87.1%	88.8%	93.3%
Beta-blocker prescribed at discharge (Evidence based) (Bisoprolol, Carvedilol, Metoprolol succinate ORXL)	97.6%	99.3%	95.5%	96.7%	89.5%	100%
LVEF Measurement	99.8%	99.6%	97.8%	98.2%	98.4%	97.5%
Follow-up Appointment at discharge	95.9%	95.3%	98.2%	94.9%	98.2%	97.0%


American Heart Association Get With The Guidelines ®
Heart Failure

Goal: Gold Plus Quality Award

- At least 85% compliance in Achievement Measures
- Plus: At least 75% compliance in in 4 Quality Measures
- CY21 & CY 22 * blue indicates better than All WI Hospitals

Quality Measures Metrics	FMLH CY 2021 N/D(%)	FMLH CY 2022 N/D(%)	FMF CY 2022 N/D(%)	FMF CY 2022 N/D(%)	FWB CY 2021 N/D(%)	FWB CY 2022 N/D(%)
Influenza Vaccination (during flu season) starts Oct 1st ends Mar 31st	77.8%	80.6%	82.1%	92.0%	79.5%	89.2%
Pneumococcal Vaccination	89.8%	88.1%	96.4%	96.5%	97.4%	96.8%
Anticoagulation for Atrial Fib/Flutter	94.3%	95.8%	97.9%	96.6%	96.8%	98.7%
DVT prophylaxis	100%	100%	100%	100%	100%	100%


American Heart Association Get-With-The Guidelines ®
Heart Failure

Goal: Honor Roll Award - At least 50% compliance

- **Process Improvement Opportunities – Honor Roll**
- CY21 & CY 22 * blue indicates better than All WI Hospitals

Metric	FMLH CY 2021 N/D(%)	FMLH CY 2022 N/D(%)	FMF CY 2021 N/D(%)	FMF CY 2022 N/D(%)	FWB CY 2021 N/D(%)	FWB CY 2022 N/D(%)
Follow-up Visit (7 Days or Less) HF Stretch Goal 65%	71.0%	66.4%	67.9%	69.2%	67.0	71.6%
Aldosterone Antagonist at discharge for HFrEF	64.8%	77.4%	52.6%	52.4%	55.6%	66.7%
Referral to Disease Management, 60 Minutes of Education, Discharge Packet	99.6%	100%	99.4%	100%	100%	100%
Diabetes-HF NEW MEASURE						
Overall Diabetes Cardiovascular Initiative Composite Score	80.8%	86.9%	83.7%	83.8%	77.6%	84.2%

Transitions of Care

IMPLEMENT-HF	AHAHF61: 30 Day ACEI/ARB/ARNI
	AHAHF107: 30 Day Defect-Free Care for Quadruple Therapy Medication for Patients with HFrEF
	AHAHF63: 30 Day Evidence-Based Specific Beta-Blocker for LVSD
	AHAHF105: 30-Day Angiotensin Receptor Neprilysin Inhibitor (ARNI)
	AHAHF98: 30-Day Health-Related Social Needs Assessment
	AHAHF111: 30-Day Mineralocorticoid Receptor Antagonist for Patients with HFrEF (LVEF < = 40)
	AHAHF97: 30-Day SGLT-2 Inhibitor at Discharge for Patients with HFrEF
	AHAHF62: 30 Day Mineralocorticoid Receptor Antagonist for Patients with HFrEF (prior to April 2022)

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Quality Outcomes Lead to External Recognition

Get With The Guideline – CY 2022 Top Awards

USNews HEALTH 2023-2024 Heart Failure Scorecards - High Performing

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Table Activity

- Identify current EHR used in your organization
- Share experiences using the current EHR reporting
- Identify one target population with an evidence based target and quality opportunities within your scope
- Share any Quality recognitions
- Report out to group

Questions?

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Thank you!

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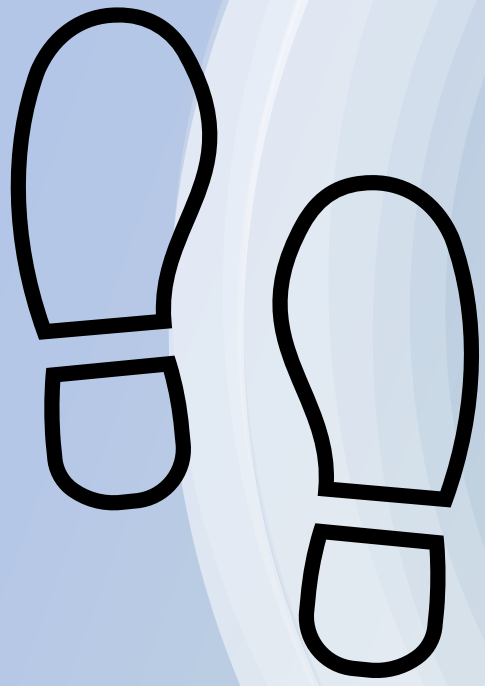

Lunch

Vendors & Storyboards Passport

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WAHQV
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Population Health
Transitions of Care Management

Laura Wieloch, MS, RN
Executive Director, Care Management—Midwest Region
Advocate Health

Advocate Health Care® | Aurora Health Care®
Now part of ADVOCATEHEALTH

Conflict of Interest Statement

I confirm that neither I nor any of my relatives nor any business with which I am associated have any personal or business interest in or potential for personal gain from any of the organizations or projects linked to this presentation.

Objectives

At the conclusion of this presentation, the attendee will:

- Define Transitions of Care
- Discuss Readmission Rates, TCM programs, TCM Visit requirements and TCM visit capture
- Discuss TCM reimbursement and readmission penalties
- Evaluate TCM opportunities, solutions
- Evaluate current state at home organization and consider opportunities for improvement

Integrated Care Management

- **Coordinates**
- **Integrates**
- **Simplifies**

the healthcare experience through

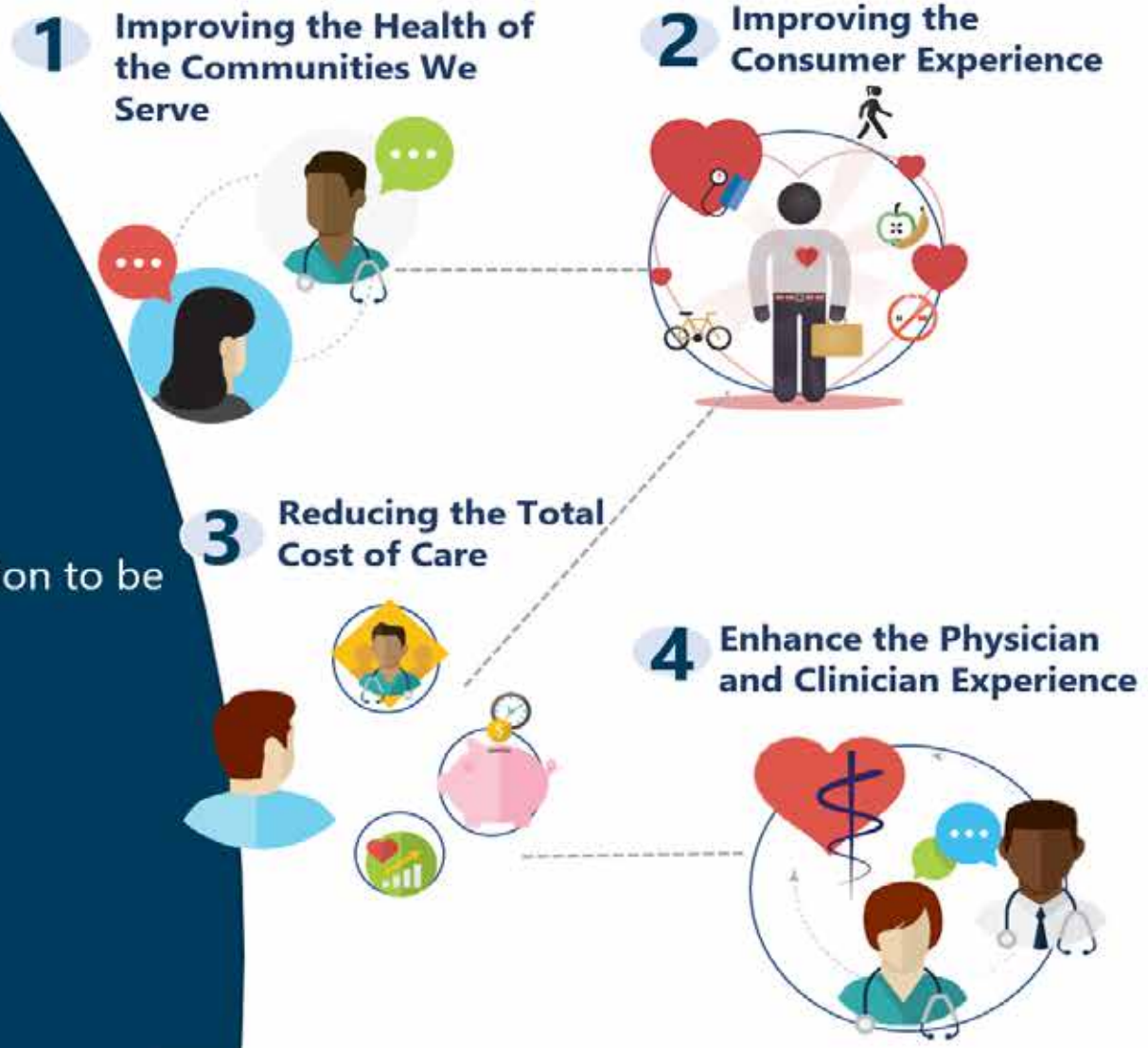
- ***Ambulatory Care Management***
- ***Inpatient Care Management***
- ***Utilization Management***

impacting the "quadruple aim" and positioning our organization to be

- **Successful**
- **Innovative**
- **Sustainable**

in **current** and **future** healthcare environments.

We Help People Live Well by...



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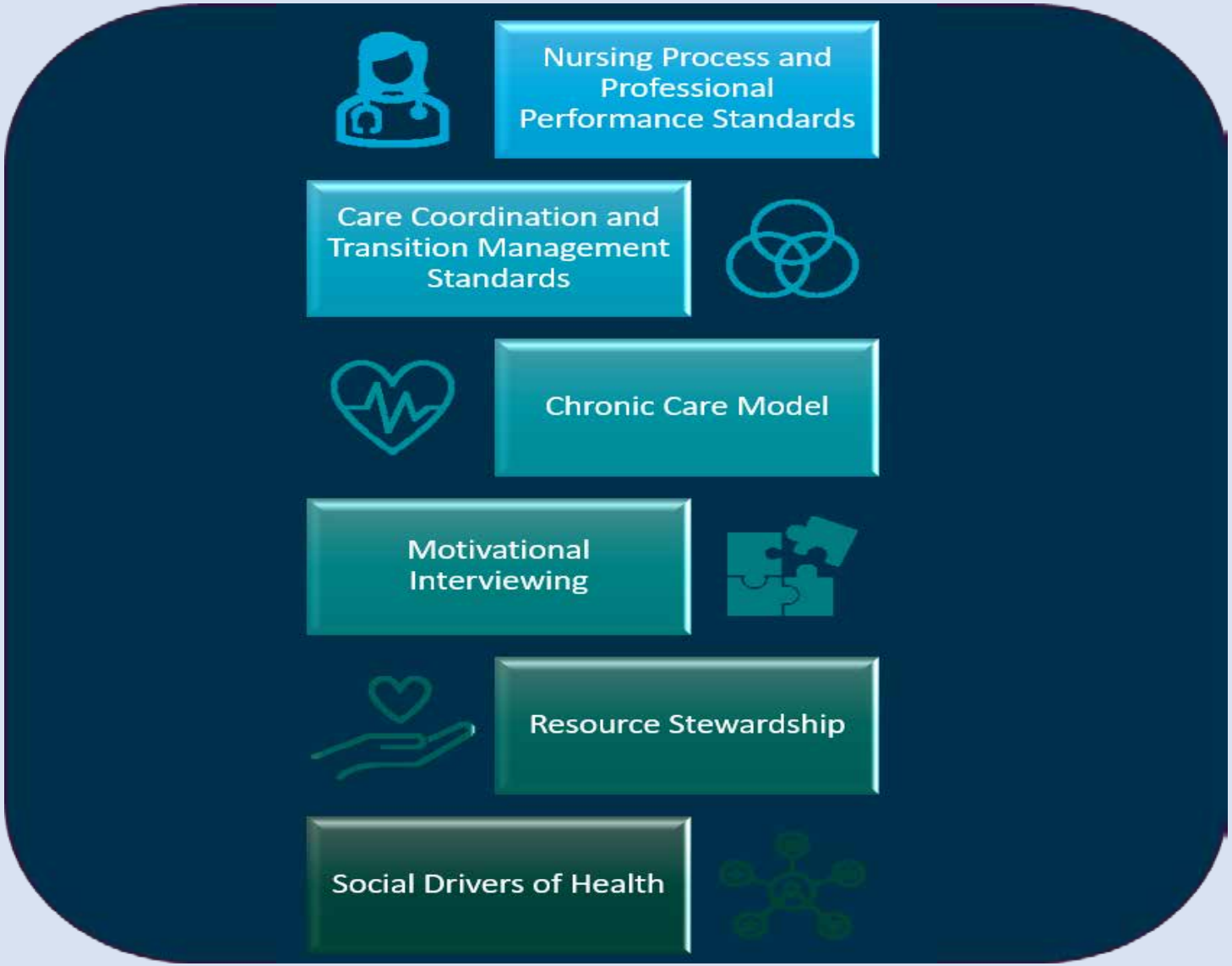
Foundational Framework



Purpose-Driven

Ambulatory Care Management's Mission

We help people live well by implementing innovative, whole-person care delivery.

What does this look like?

- Proactively identifying and engaging vulnerable populations in the community
- Wrapping integrated and seamless support around patients as they move across the care continuum in pursuit of optimal well-being.
- Innovating clinical care with technology to extend our reach and increase self-management
- Developing genuine patient partnerships that recognize diversity, leverage strengths, and spark internal motivation
- Collaborating with multidisciplinary, cross-continuum internal and external partners
- Applying the art and science of social work, behavioral health, and nursing to support high quality and cost-efficient outcomes

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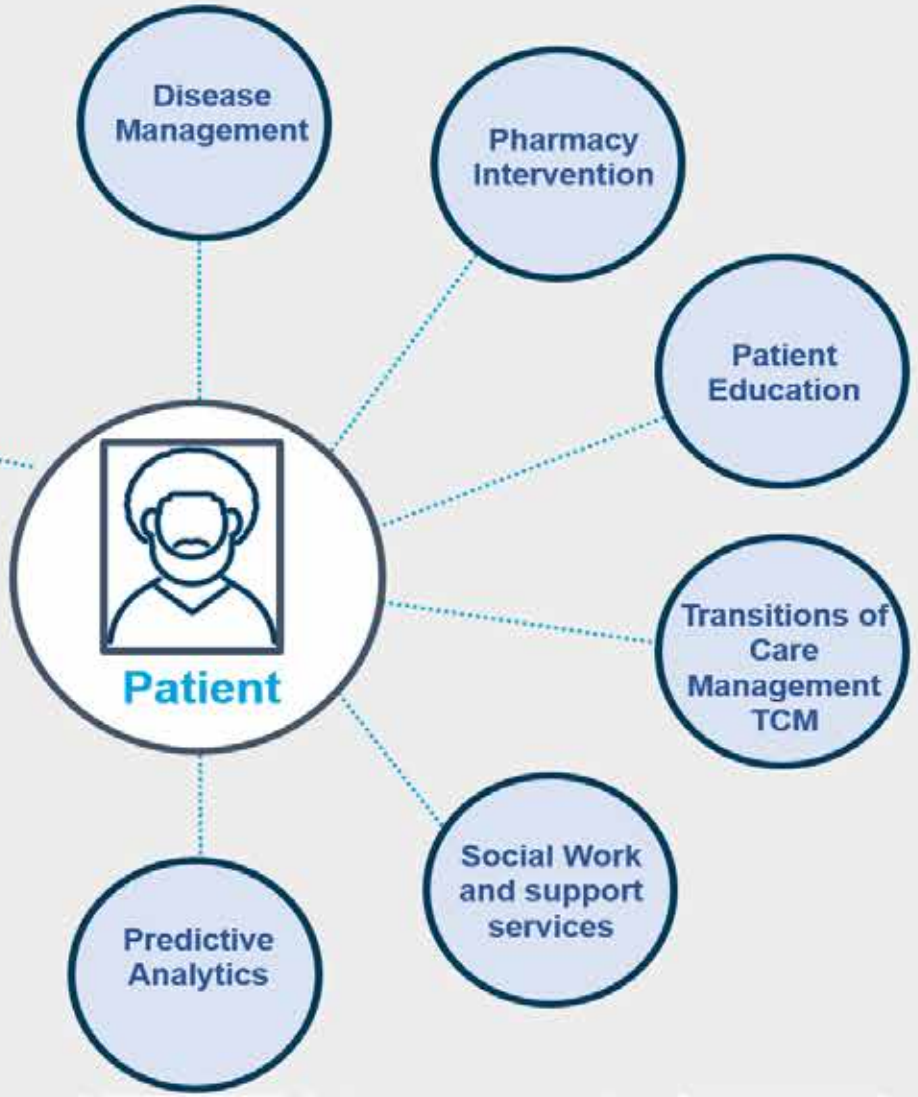
Value: Ambulatory Care Management

Care managers

Support a multi-disciplinary clinical team to ensure patients receive the

right care at the
right time in the
right setting by the
right provider to manage health outcomes and costs.



Safety

Quality

Patient Experience

Days at Home

Hospital Admissions

Readmissions

ED Visits

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Value: Ambulatory Care Management

Care managers
Support a multi-disciplinary clinical team to ensure patients receive the
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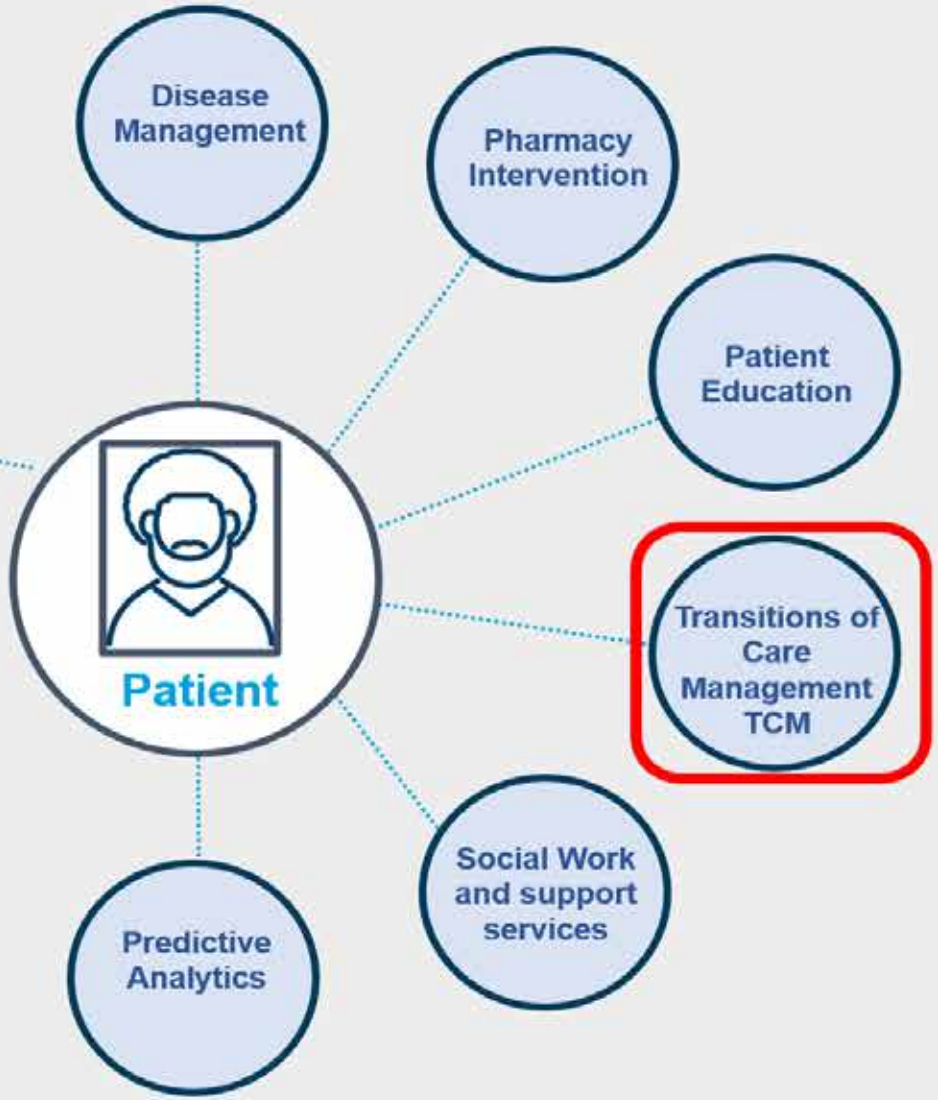

- Safety
- Quality
- Patient Experience
- Days at Home

- Hospital Admissions
- Readmissions
- ED Visits

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What is Transitional Care Management?

Transitional Care Management (TCM) are services offered during the hand-off period between the inpatient setting and the community setting.

- 30 days—begins on day of discharge and continues for 29 days
- Includes face-to-face visit:
  - within 7 days for high-risk patients (CPT: 99496)
  - within 14 days for moderate/low risk patients (CPT: 99495)
  - Requires medication reconciliation on or before visit
  - Requires interactive contact with patient within 2 business days of discharge

Transitional Care Management Services (cms.gov)

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TCM Opportunities: Clinical and ROI

- Increase “days in home”
- Patient Safety
- Patient Experience/satisfaction
- Increase Revenue from 99495/96 CPT codes vs E&M codes (99212-15)
- Readmission reduction strategy—reduce readmission penalties
- Reduce excess days
- Improve STARS measures
- Reduce Total Cost of Care (TCOC)

The TCM Journey

Patient ID

Pre Discharge

Patient Scheduling

2 Day Interactive Contact

TCM Visit

Typical

Multiple work queues/workflows; organic processes

Risk Scoring varies by State or Market

Care Transitions
Clinic RNs
Care Coordination
Call Center
Hospital follow up RNs
Unit Nurses

Multiple encounters used for documentation; reporting discrepancies

Varied documentation for interactive contact
Lack of clarity on eligibility for visit
Varied/missing documentation needed for treatment/billing

Ideal State

Single source of truth for eligible discharge data

Single hospital documentation discharge template including readmission risk score

Single source hospital visit closure to capture scheduling

Single source RN workflow for all eligible high-risk patients
Automated system for low/moderate risk patients and Observation discharges

Smarter Note TCM template for visit and billing
TCM documentation from 2-day contact is easily visible
100% opportunity to capture TCM charge if visit is performed within 14 days

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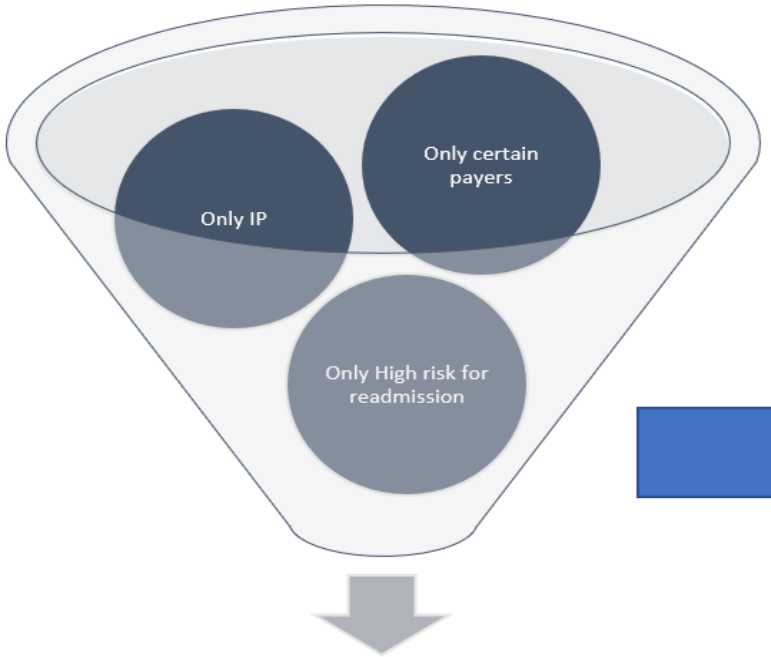
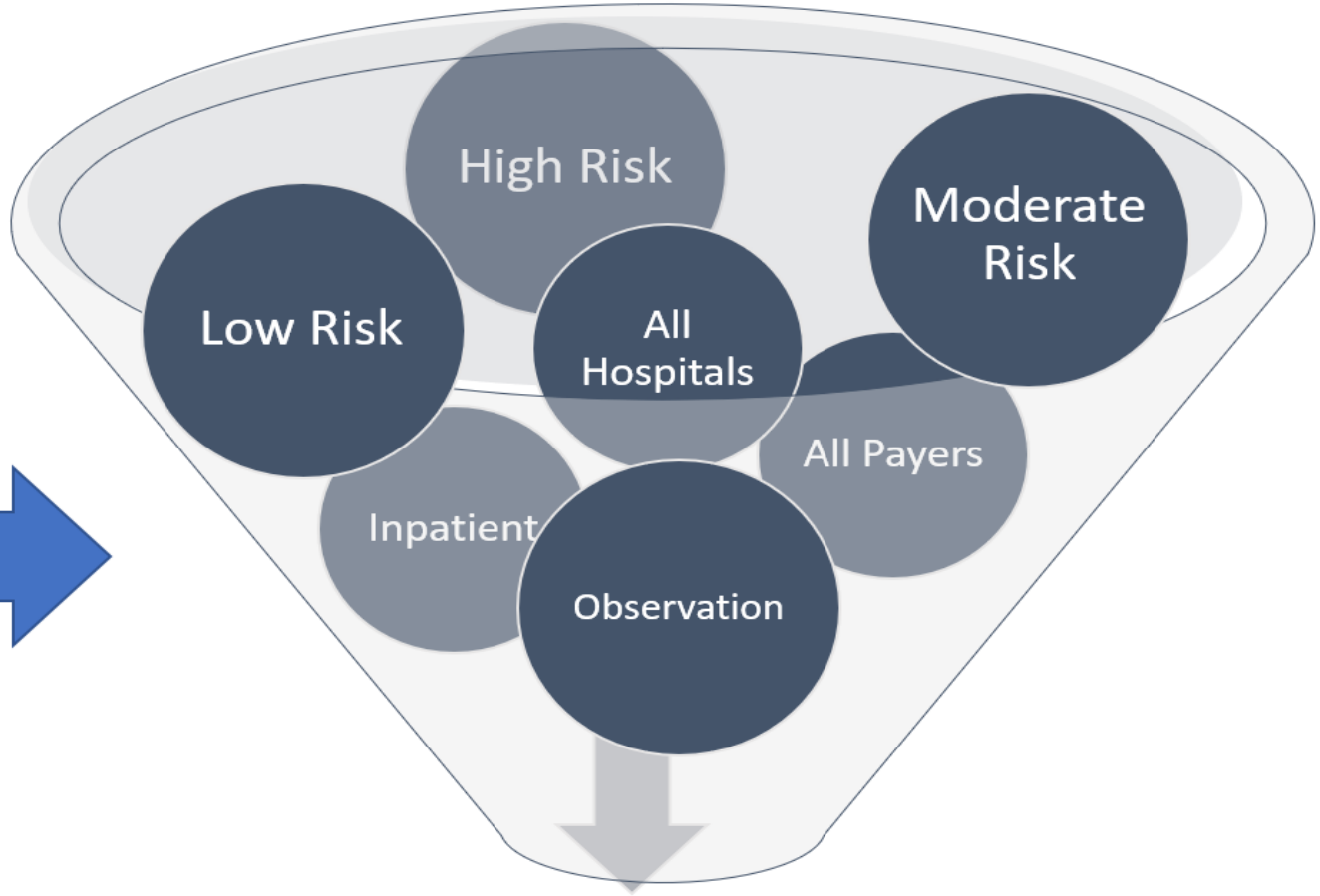
Standard Work– Widens the Funnel





Not inclusive of all eligible discharges
Limited capture of TCM visits
Negative impact on readmissions

All eligible patients included
Increase TCM visit capture
Readmission cost reduction

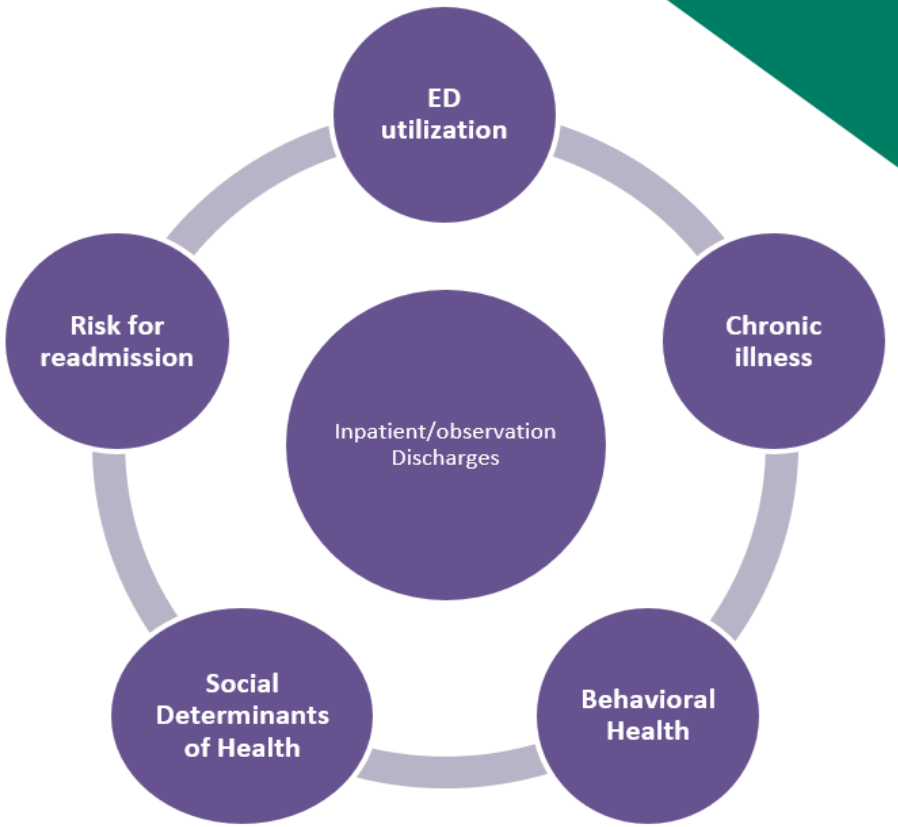
Discussion—10 minutes

Please share around your table any best practices, or lessons learned from any TCM work at your organization

Integrated, Wrap Around Care

Care Transitions

- ✓ Manage high risk for readmission patients discharged from Inpatient
- ✓ 30-day program
- ✓ **TCM interactive contact within 2 business days**
  - Uses EPIC TCM module for documentation
- ✓ Multidisciplinary team which includes:
  - Inpatient Care Managers
  - Social Workers, Community Health Workers
  - Pharmacists
  - Behavioral Health Navigators
- ✓ Telephonic, zoom visits



Clinically and Statistically Significant Results

WI Care Transitions Program Results

Care Transitions RN vs. No Care Transitions RN

risk-adjusted patient populations, same time frame

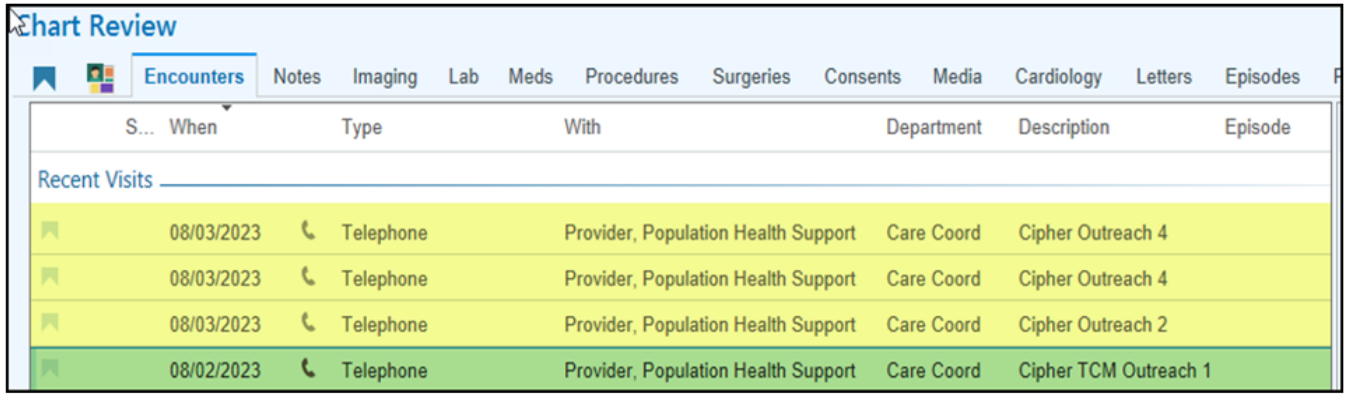
38%

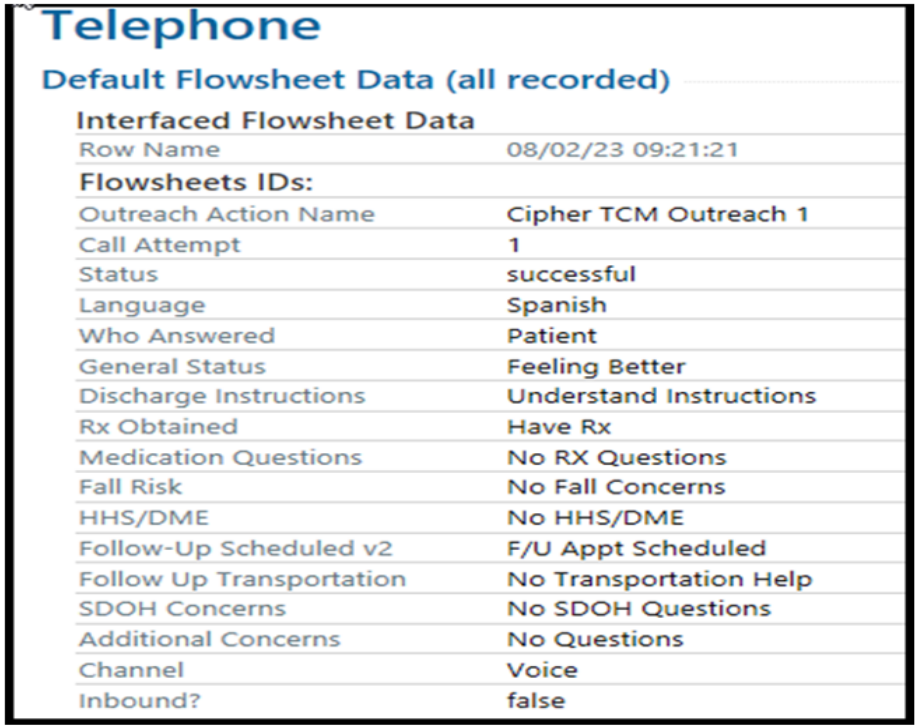
Inpatient readmissions

(p=0.008)

Care Transitions—Low/Mod Risk

- ✓ Low and moderate risk for readmission patients receive weekly outreach for 30 days via **Cipher IVR or text**
- ✓ Cipher is fully integrated into Epic
- ✓ CTP RNs manage alerts dashboard 7 days per week





Cipher Health Clinical Technology

Targeted Clinical outreach for care transitions, and health outreach to close quality care gaps

- ✓ Automated, interactive phone calls and SMS text messages
- ✓ Ability to provide messaging in English and Spanish
- ✓ Support population health clinical care management and health outreach in large volumes
- ✓ Patients have the ability to live transfer or request a call back
- ✓ Real-time reporting to drive operational change
- ✓ Demonstrated improvements in clinical quality measures, and clinical outcomes including readmissions reduction across the system

Personalized Features Effectively Engage Patients

Caller ID

Make sure the phone displays that healthcare organization's branded program.

Timing of Outreach

Customize the times of day and days of the week that calls or texts will go out.

Multiple Languages

Utilize multiple languages to meet the needs of your patient population.

Local Area Code

Call patients using a number with a local area code. Do not display 1-800, 1-555, etc.

Voice Talent

Record the voice of someone at your facility that is familiar to the patient.

Mode of Communication

Call patients by phone or SMS. Allow patients the option of an inbound call as well.

Patients are asked a series of questions via Call or SMS each week for 30 days after discharge.

Questions Focus on:

- New or changing symptoms
- Questions related to D/C instructions/AVS
- Medications
- Safety Concerns (falls)
- Anticipated services (DME, Home Care)
- TCM/Specialty Appointments
- Transportation concerns
- SDOH concerns (finances)

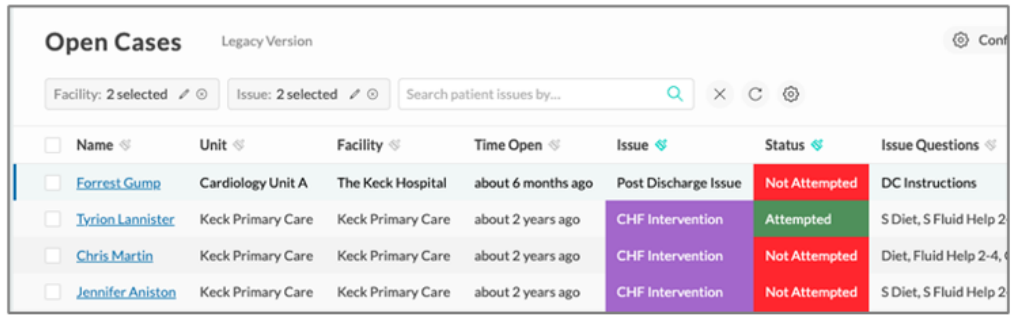
Care Team Intervention

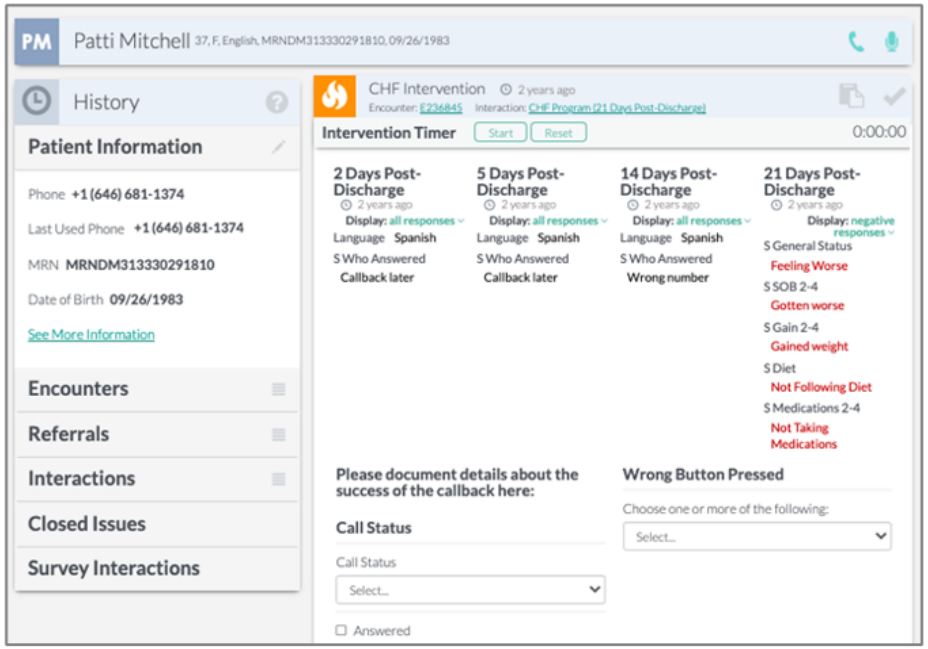
If a patient indicates an issue, an automatic alert will be triggered to the appropriate staff member or team for resolution

Care Transition RN's monitor this dashboard

They will call the patient upon receipt of the alert

The program is staffed 7 days a week





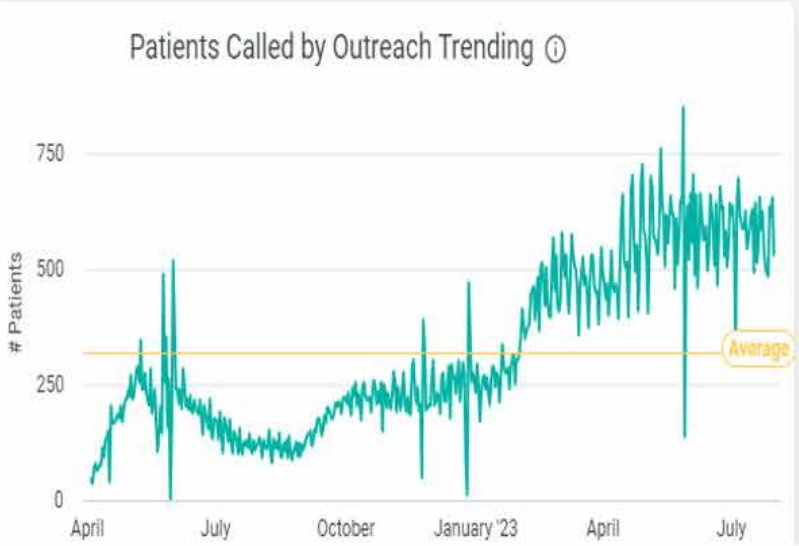
Midwest Region

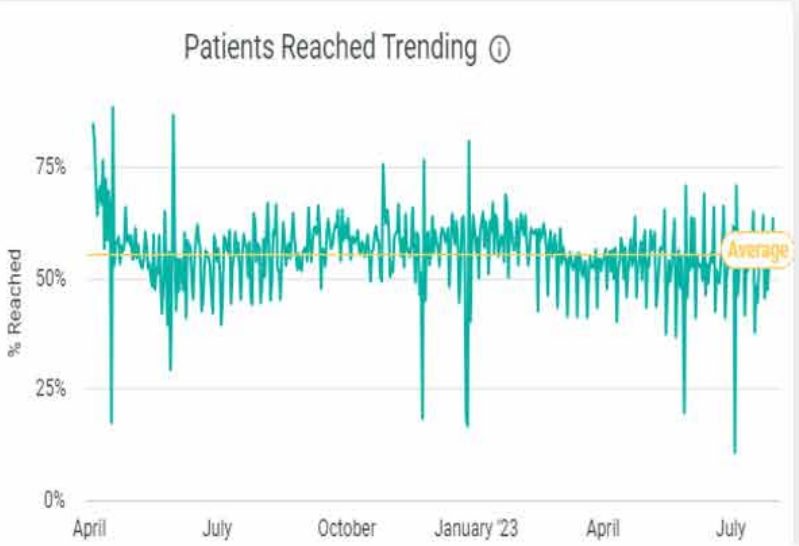
Answered Any Question & Issue Rate thru 7/31/23

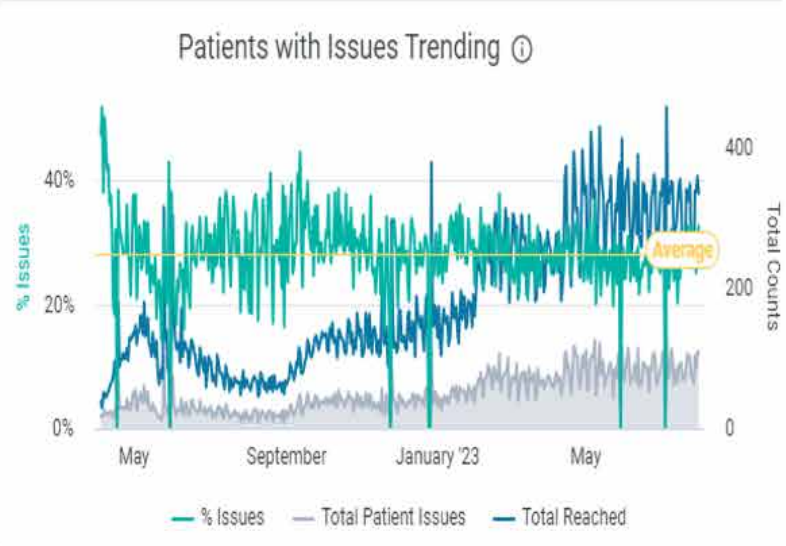
37,056
Patients Called by Outreach

82%
of Patients Reached

54%
of Patients with Issues

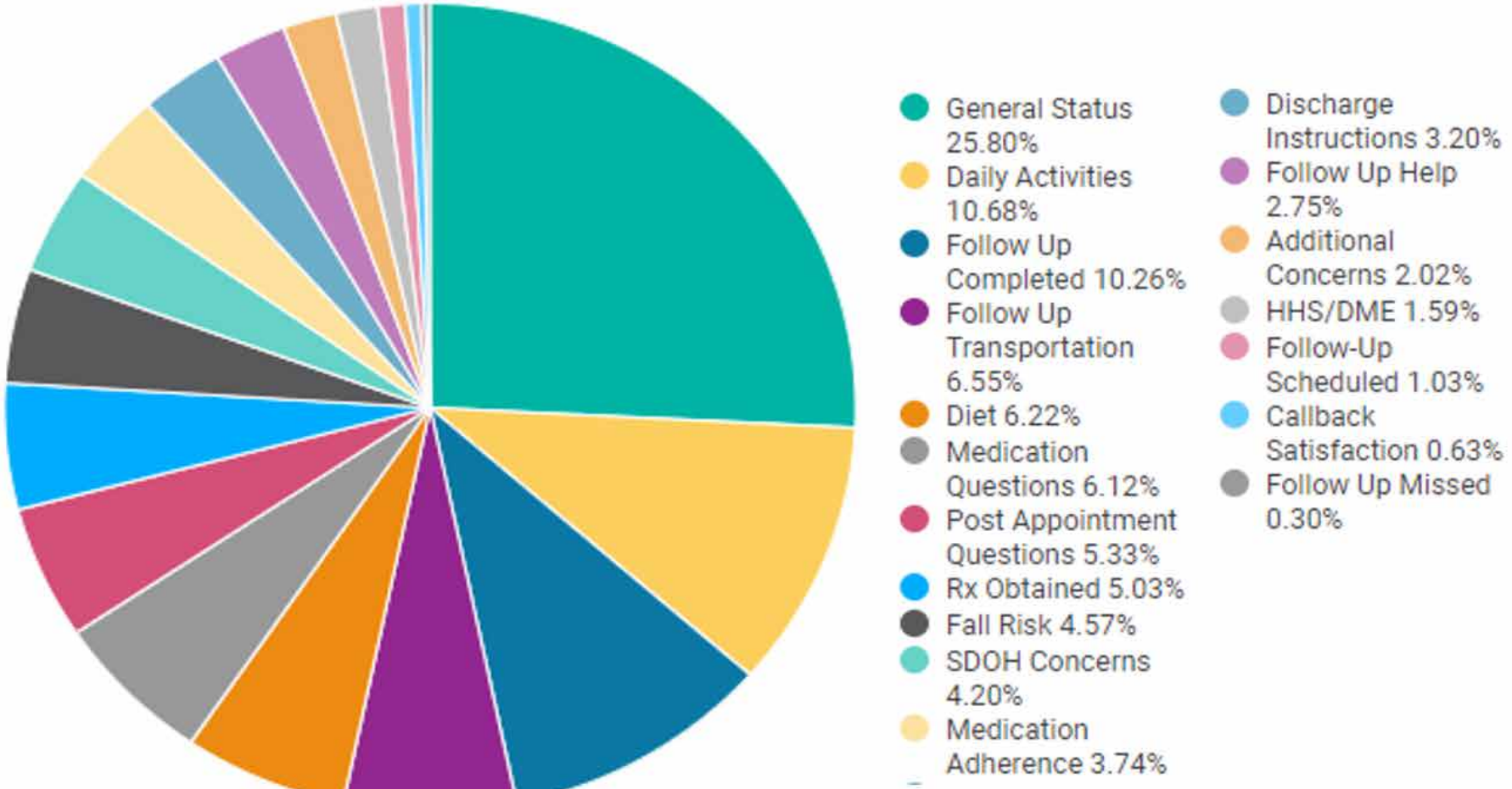






Reach Rate = 99%

Midwest Region Response Breakdown



CT RN's outreach to **84%** of patients within 3 hours of the alert.

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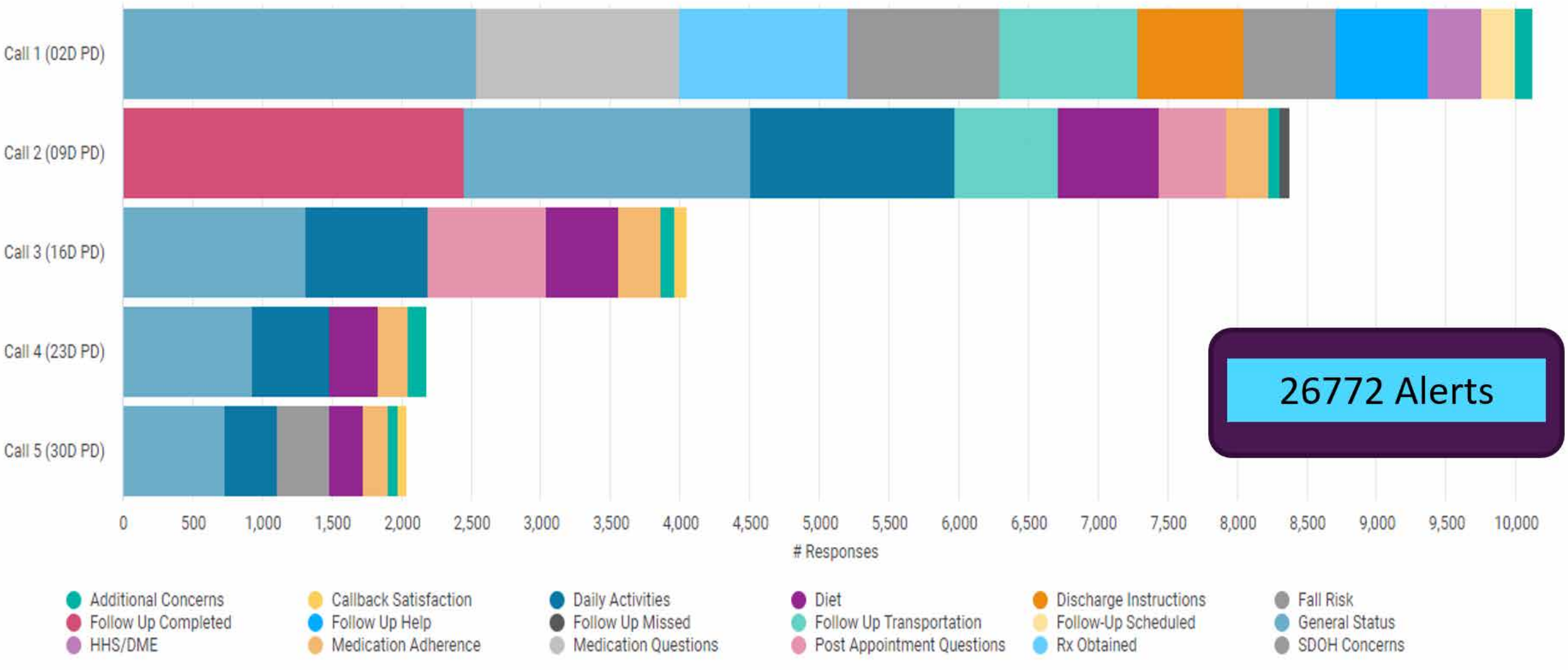
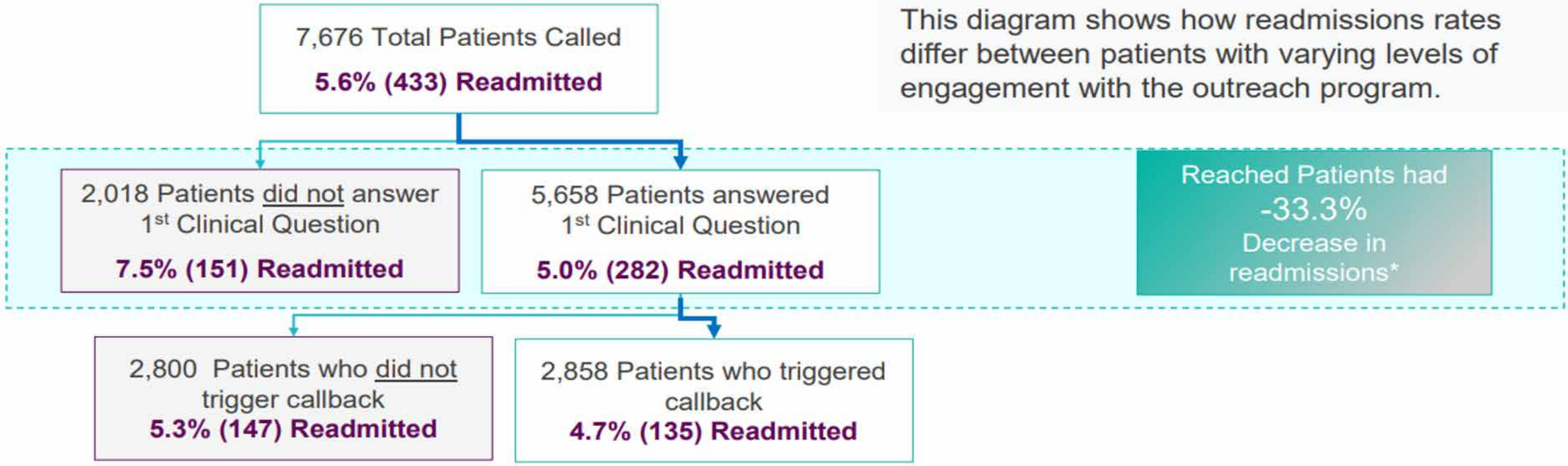
Midwest Region Response Breakdown by Call Number



30 Day Readmission Tree Diagram (All Programs)



This diagram shows how readmissions rates differ between patients with varying levels of engagement with the outreach program.

Reached Patients had
-33.3%
Decrease in readmissions*

*calculated as a % change, (7.5% - 5%)/7.5%

Report Period: 4/6/22 – 10/31/22

Patient Letter

Hi Kari,

I recently had serious life-disrupting surgery at Good Shepherd Hospital and was contacted by your Cipher program. I subsequently received a call from nurse Jaime [redacted] and have spoken with her a few times since. I would normally be a little skeptical that such a program would offer any benefit, but since I was experiencing complications from the surgery and confusion about some information I was given, I confided in Jaime as to my symptoms and frustration.

Jaime could not have been more helpful, offering a compassionate listening ear, a knowledgeable medical perspective to my situation and much-needed follow-up.

I consider the new program to be a success (at least in my case) and Jaime to be a credit to the medical community and your organization. Thank you for your time.

Regards,

References

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Questions?

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Thank you!

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Self-Management Strategies and Motivational Interviewing (MI)

Cindy Kollauf MS, RN, ACNS-BC
Nursing Professional Development Specialist
Advocate Aurora Health

Conflict of Interest Statement

I confirm that neither I nor any of my relatives nor any business with which I am associated have any personal or business interest in or potential for personal gain from any of the organizations or projects linked to this presentation.

Objectives

At the conclusion of this presentation, the attendee will:

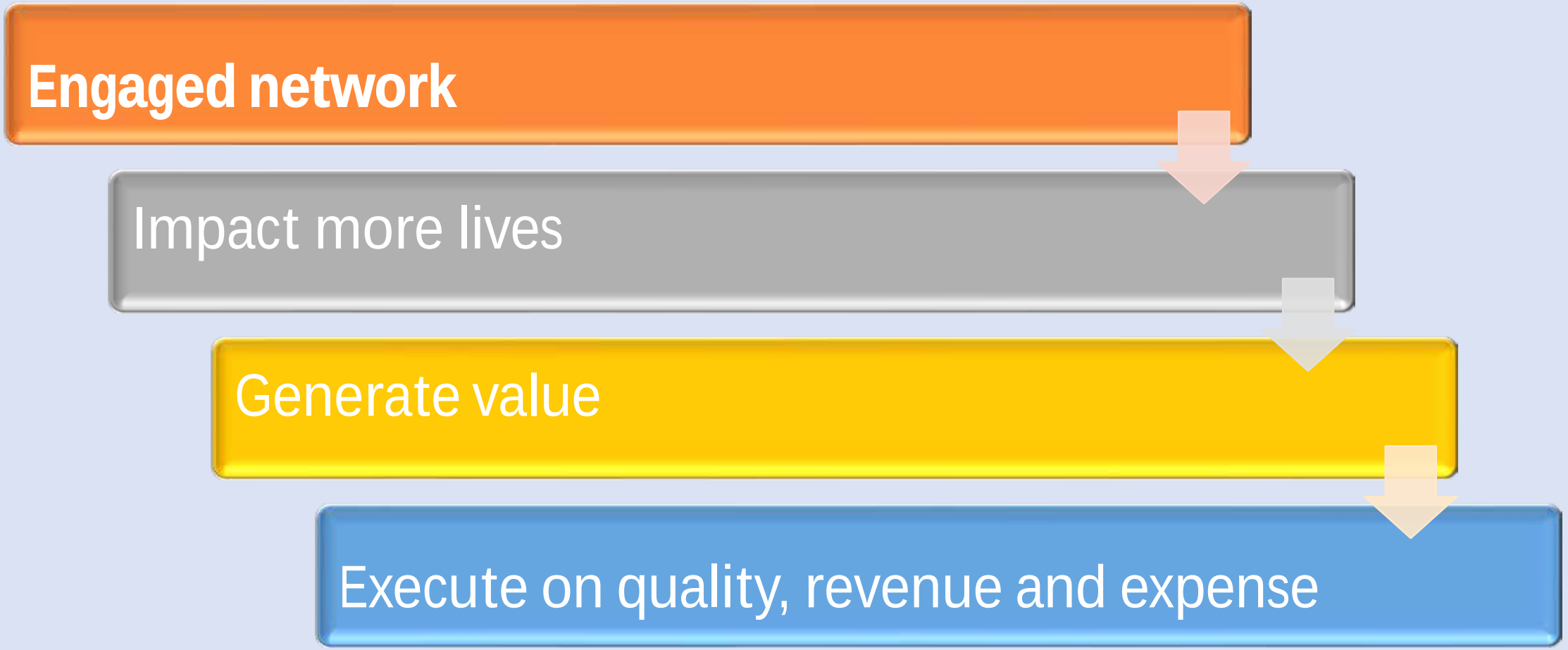
- Describe foundational knowledge of Motivational Interviewing spirit, tools, processes and benefits.
- Identify strategies for applying Motivational Interviewing techniques using a case study format.
- Compare and contrast Motivational Interviewing-centered care vs. traditional care in enhancing patient self-management.
- Review the tenets of integrating Motivational Interviewing into a health care practice culture.

Consider the Following

*"People are generally better persuaded by the reasons which **they themselves** discovered than by those which have come into the mind of others."*

- *Blaise Pascal, 17th Century French mathematician, physicist, and philosopher*

Population Health Aims



Health Care Strategies

Standardization

Evidence Based Practice

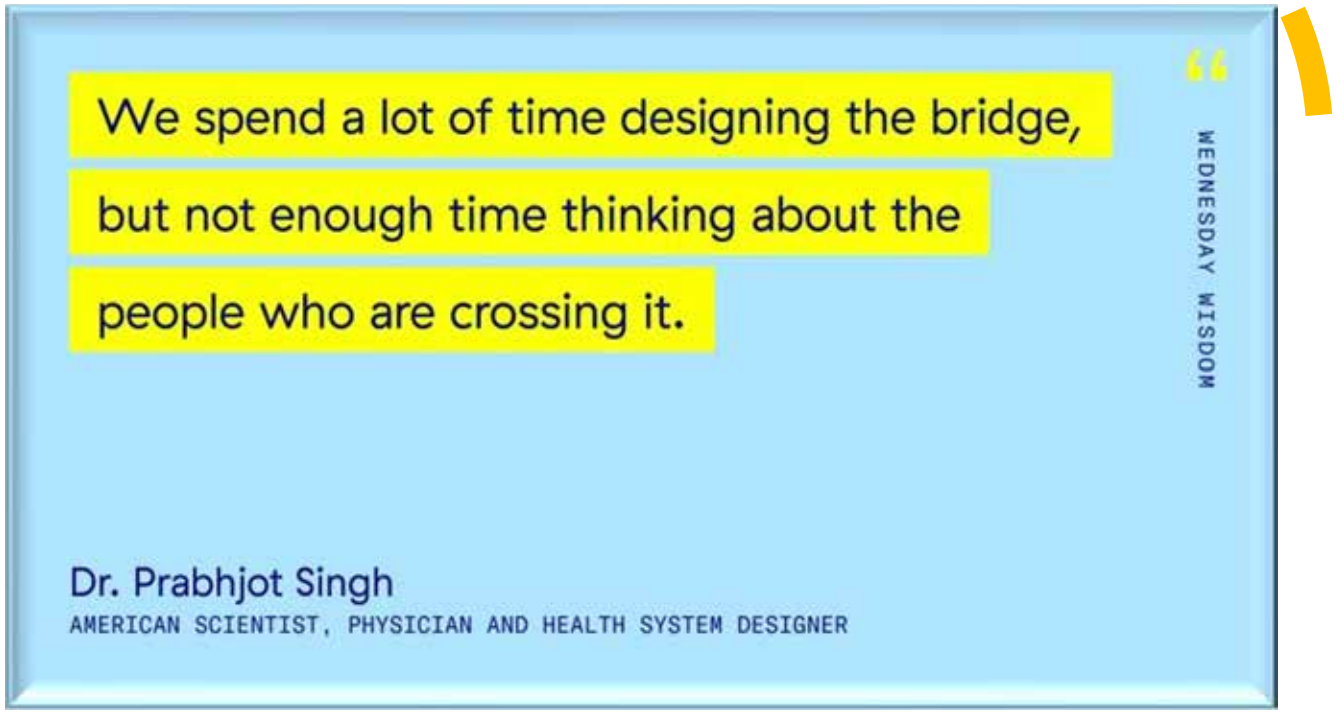
Electronic Health Record

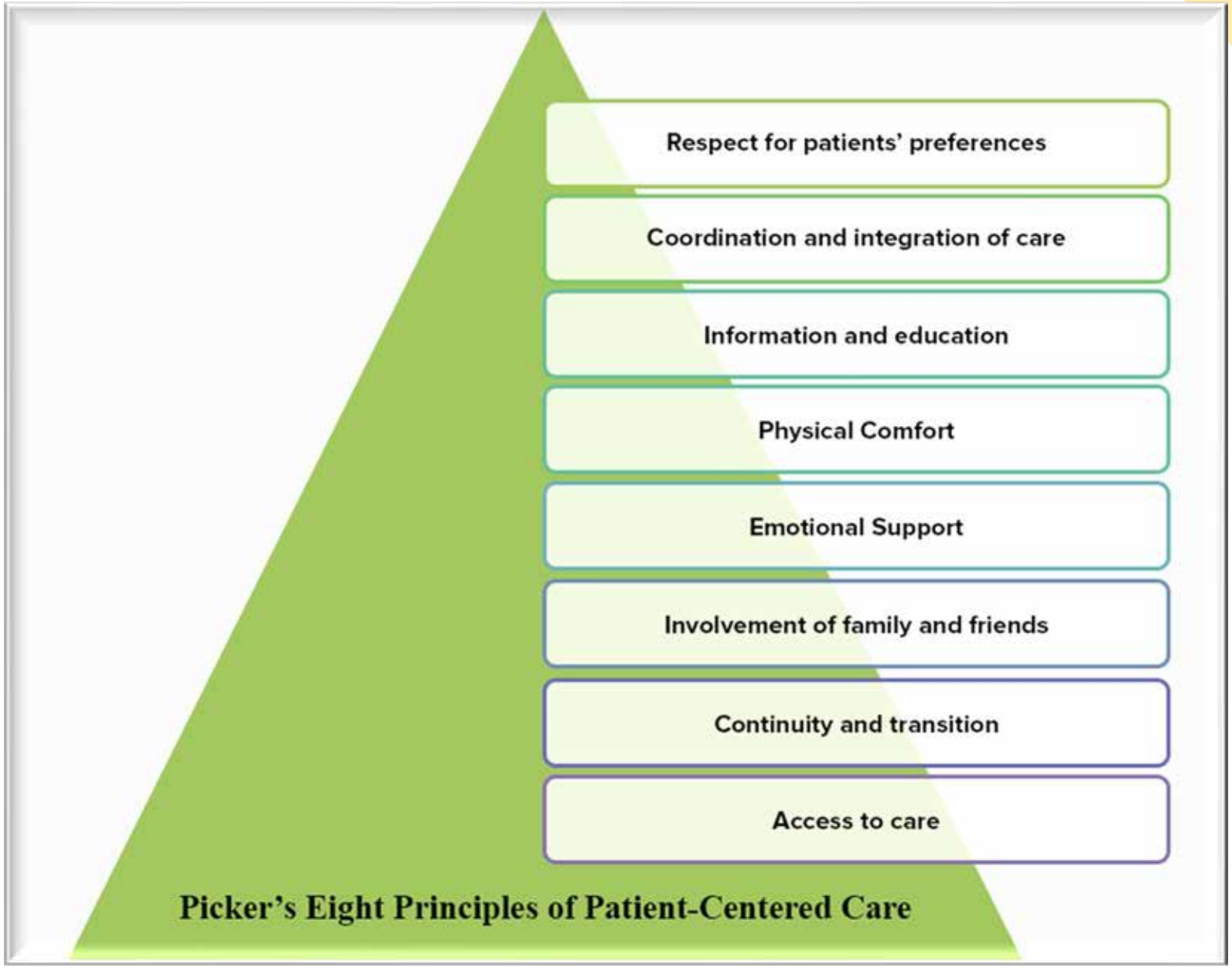
Quality Outcomes

Benchmarks

Metrics

Patient-Centered Care

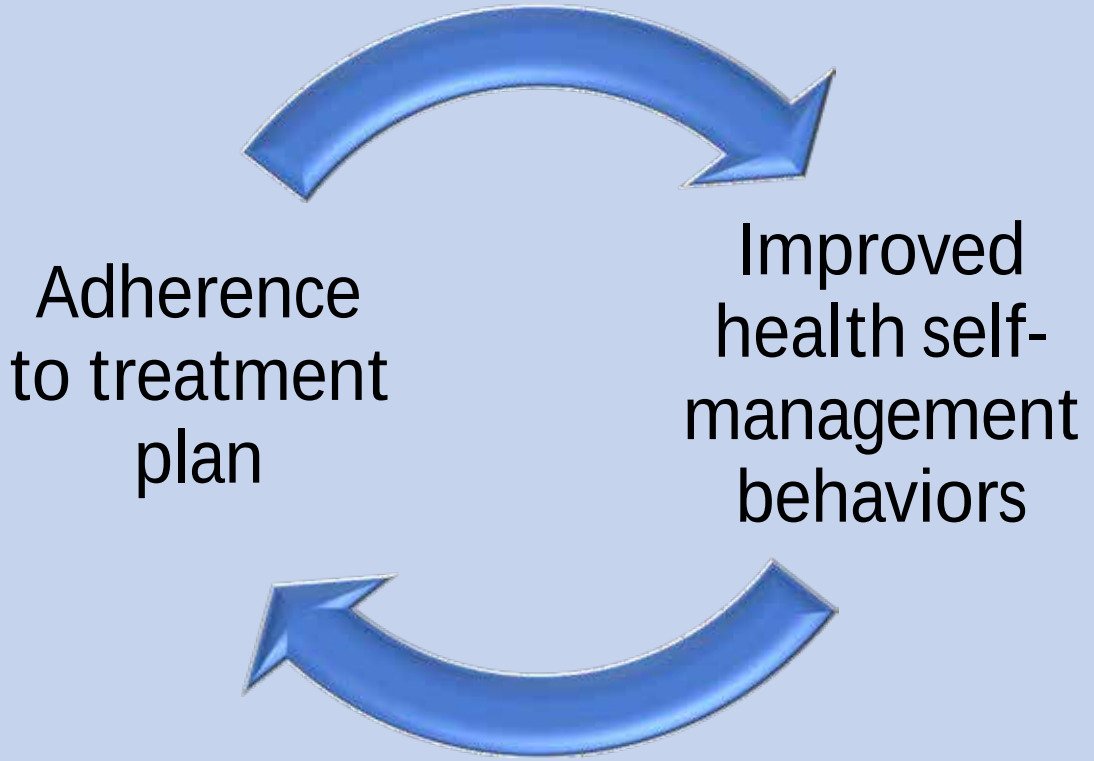




Almu, Bello & Dankani, Ibrahim. (2021). Healthcare Providers and Outpatients Relationship: A Study of Three Selected Public Hospitals in Sokoto Metropolis. International Journal of Research and Innovation in Social Science. 05. 300-306. 10.47772/IJRISS.2021.5218.

Chronic Condition Management Conundrum

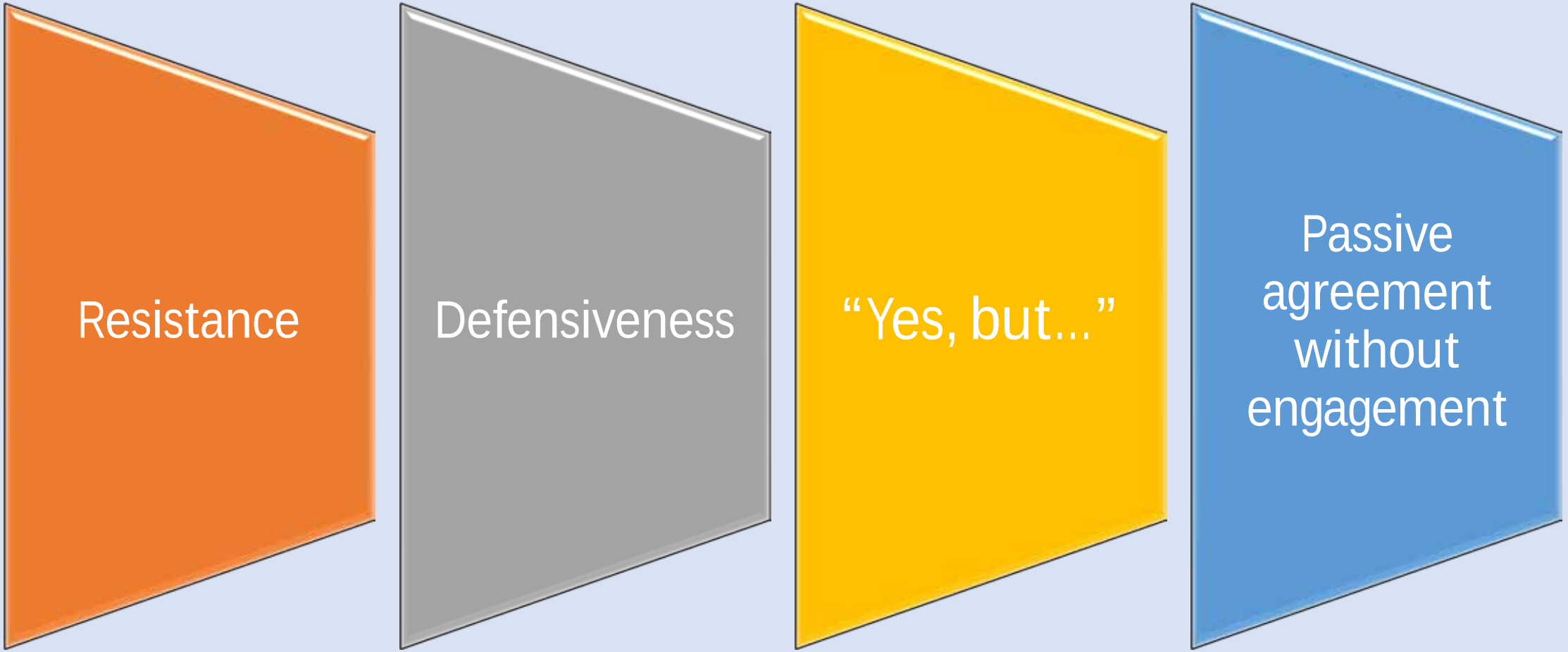
How Do We Get Outcomes ???



Traditional Approach to Improved Health-Self Management

Tell	Warn	Advise	Persuade
Refer	Problem-Solve	“Educational Materials”	Provider Frustration

How Do Patients Respond?

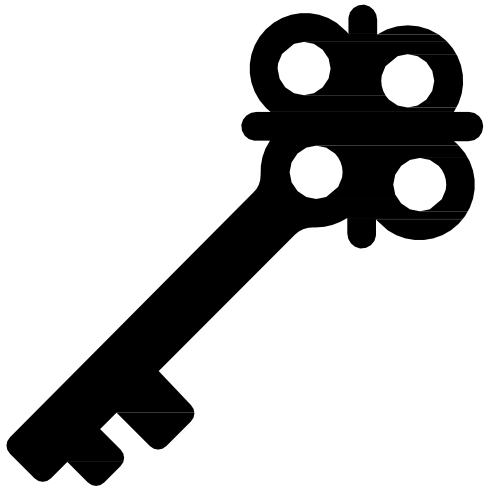


Why Don't They Change?

- Different Priorities
- Ambivalence
- Readiness to Change
- Decisional Balance
- Lack of Confidence

Chronic Condition Management

Knowing the patient as a whole person



Motivational Interviewing (MI)

Motivational Interviewing is a method for communicating and relating that is grounded in compassion and acceptance designed to strengthen personal motivation to change.

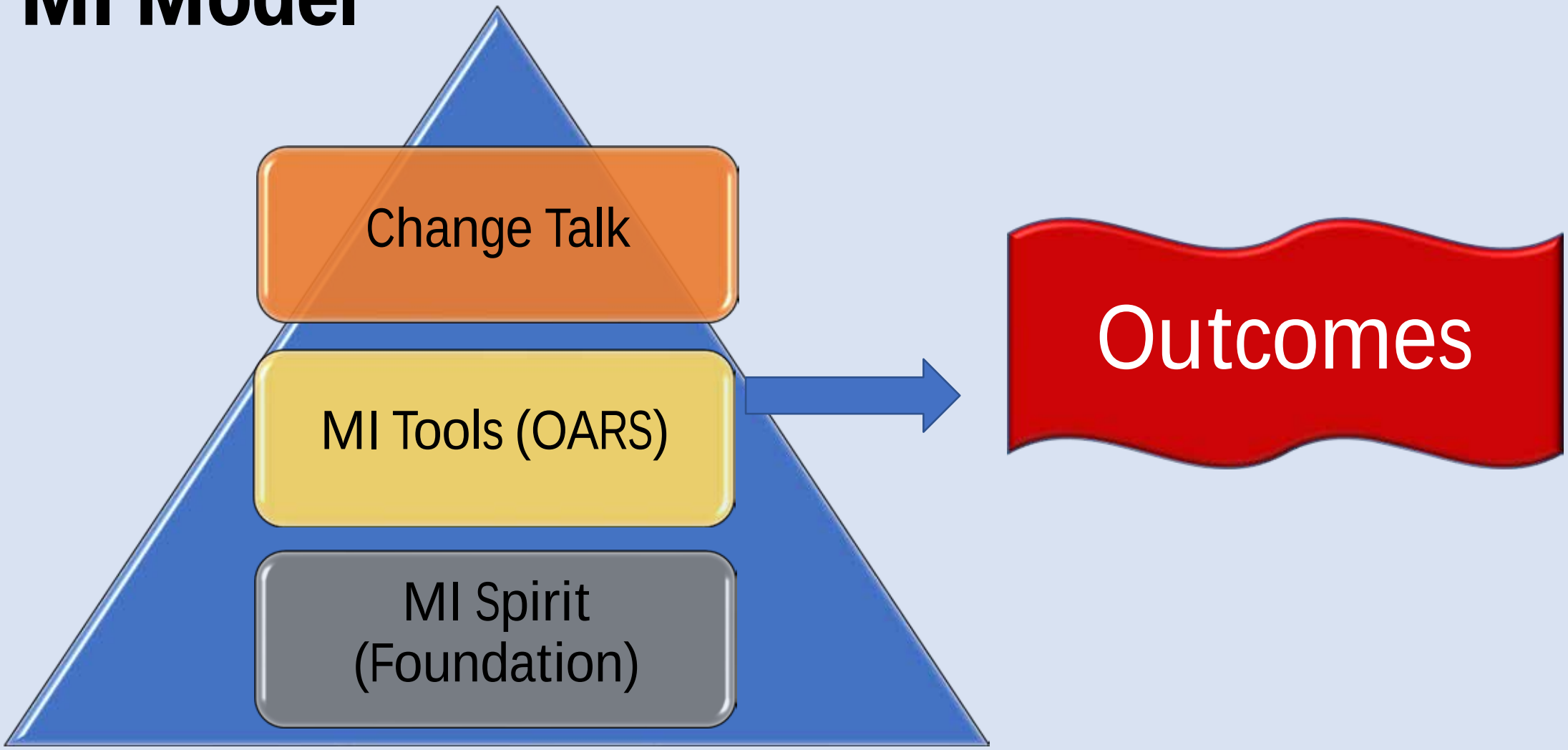
It focuses on eliciting and exploring the person's own reasons for and process of change.

"People are generally better persuaded by the reasons which they themselves discovered than by those which have come into the mind of others."

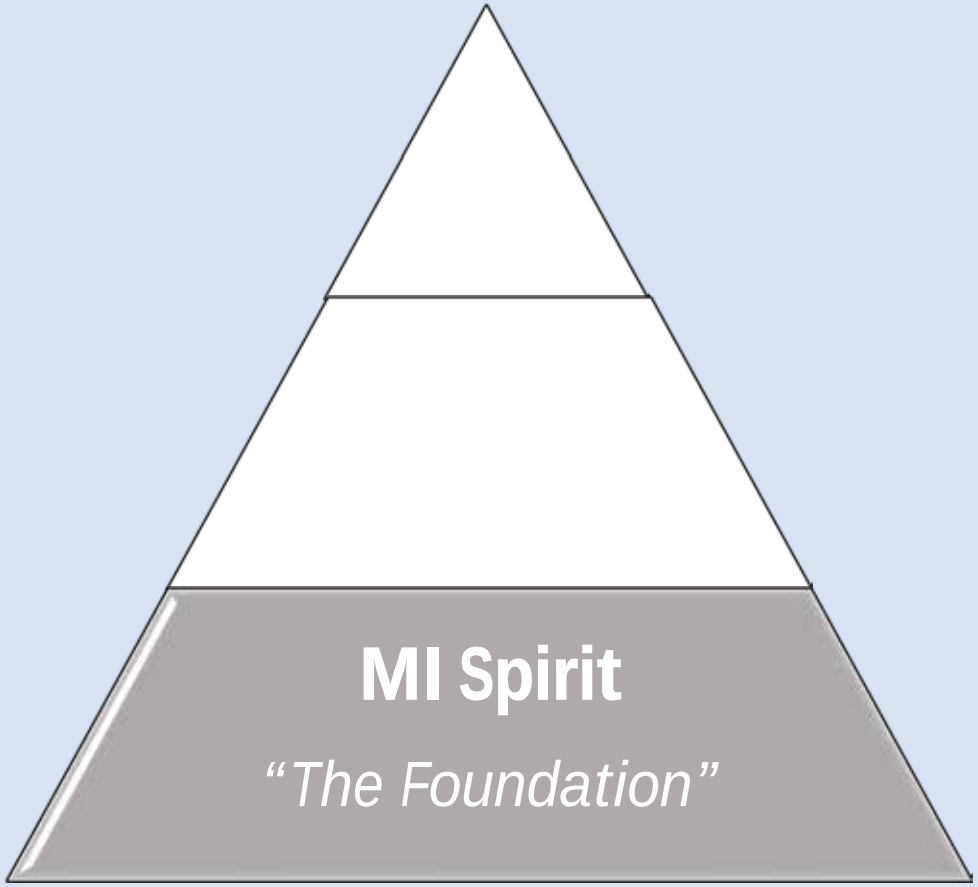
- Blaise Pascal, French mathematician, physicist, and philosopher

The “Why” of MI in Chronic Condition Management

MI Model



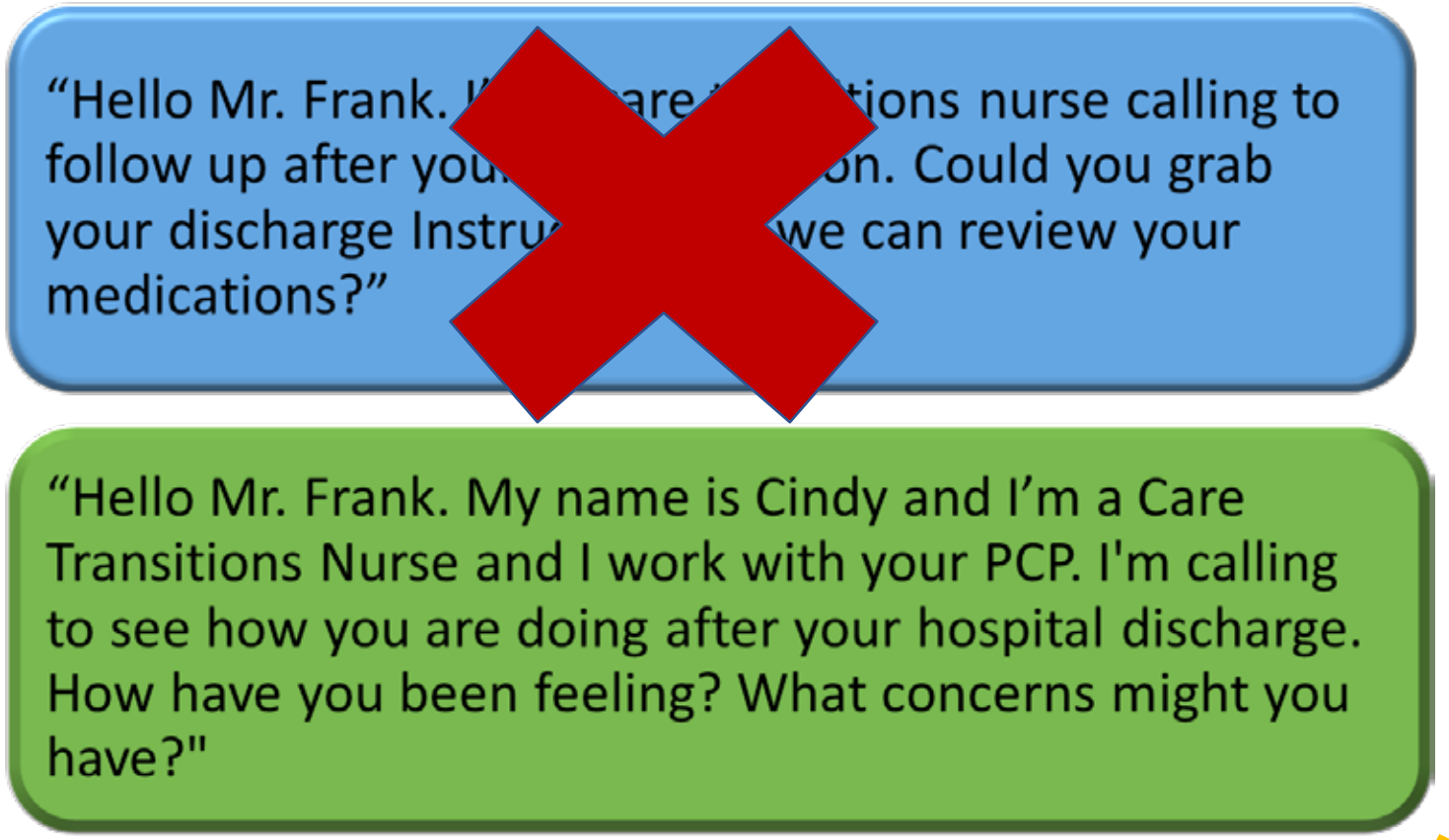
Motivational Interviewing Principles: MI Spirit



"PACE"

- **P**artnership
- **A**cceptance/**A**utonomy
- **C**ompassion
- **E**vocation

Consistent or Inconsistent with MI Spirit?

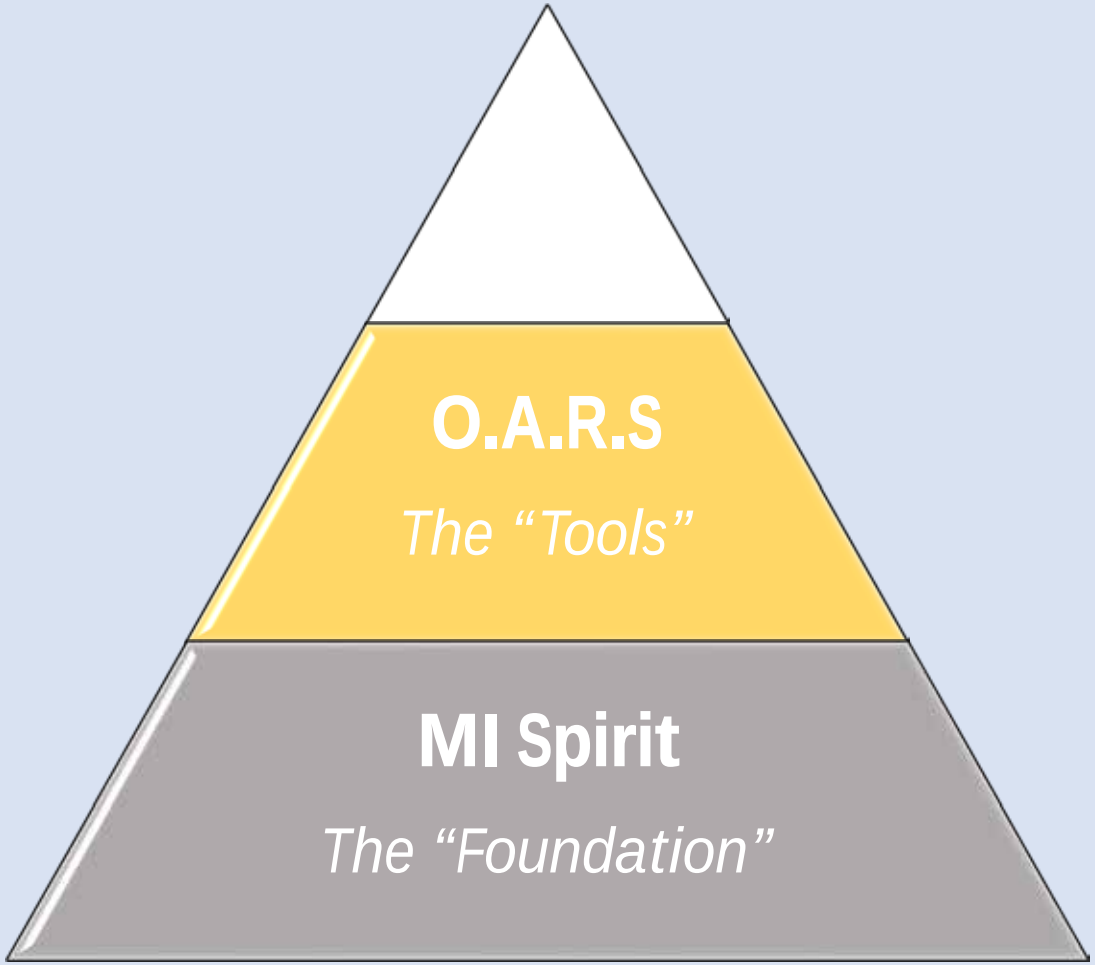


Consistent or Inconsistent with MI Spirit

"You have y… …medications, right? "

"I see that some new medications were prescribed at discharge. Can you tell me whether and how you have added them into your home medication plan?"

Motivational Interviewing Tools: OARS



- **O**pen-ended questions
- **A**ffirmations
- **R**eflections
- **S**ummaries

Open-Ended Questions in Chronic Condition Management

OARS

Openers	• "What are your biggest concerns since being discharged from the hospital?"
Assessment/Symptom Monitoring	• "Tell me about your typical morning and how you manage with your current strength and endurance?"
Medication Management	• "How do you manage your medications at home and work in any new medication changes to your routine?"
Health Management	• "With the concern about fluid build-up……high BP……low BS, how would you monitor that?"

OARS: Affirmations

"You" Statements

- Identifies a strength, value, attempt, success
- Builds Self Efficacy
- Increases Change Talk
- ***"Can Change Their World View"***

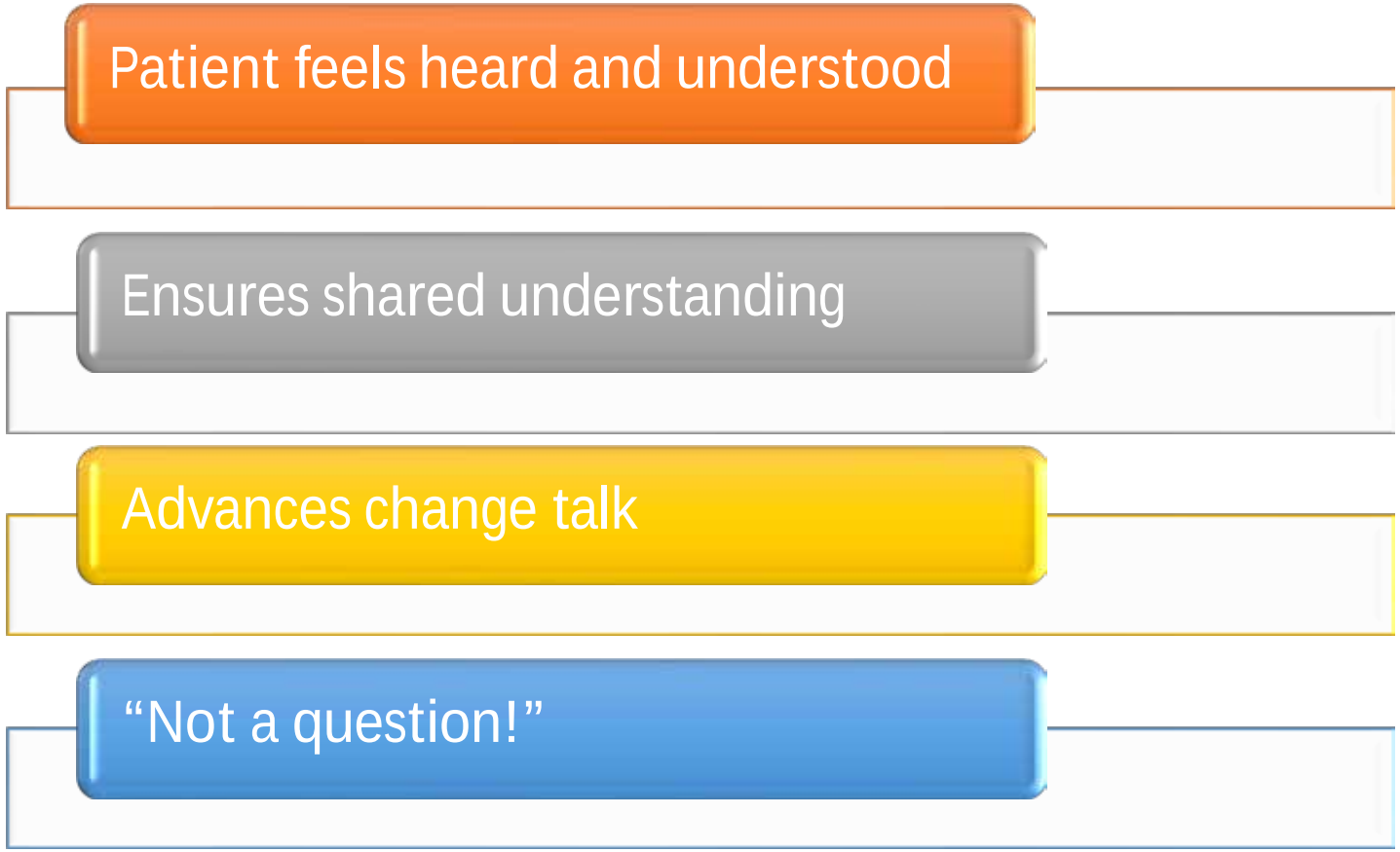
Affirmations: “This or That”

“I’m so happy you read through the packet! That’s great!”

“You” Statement

"You have put a lot of effort into being informed about what's important for your health."

OARS: Reflections



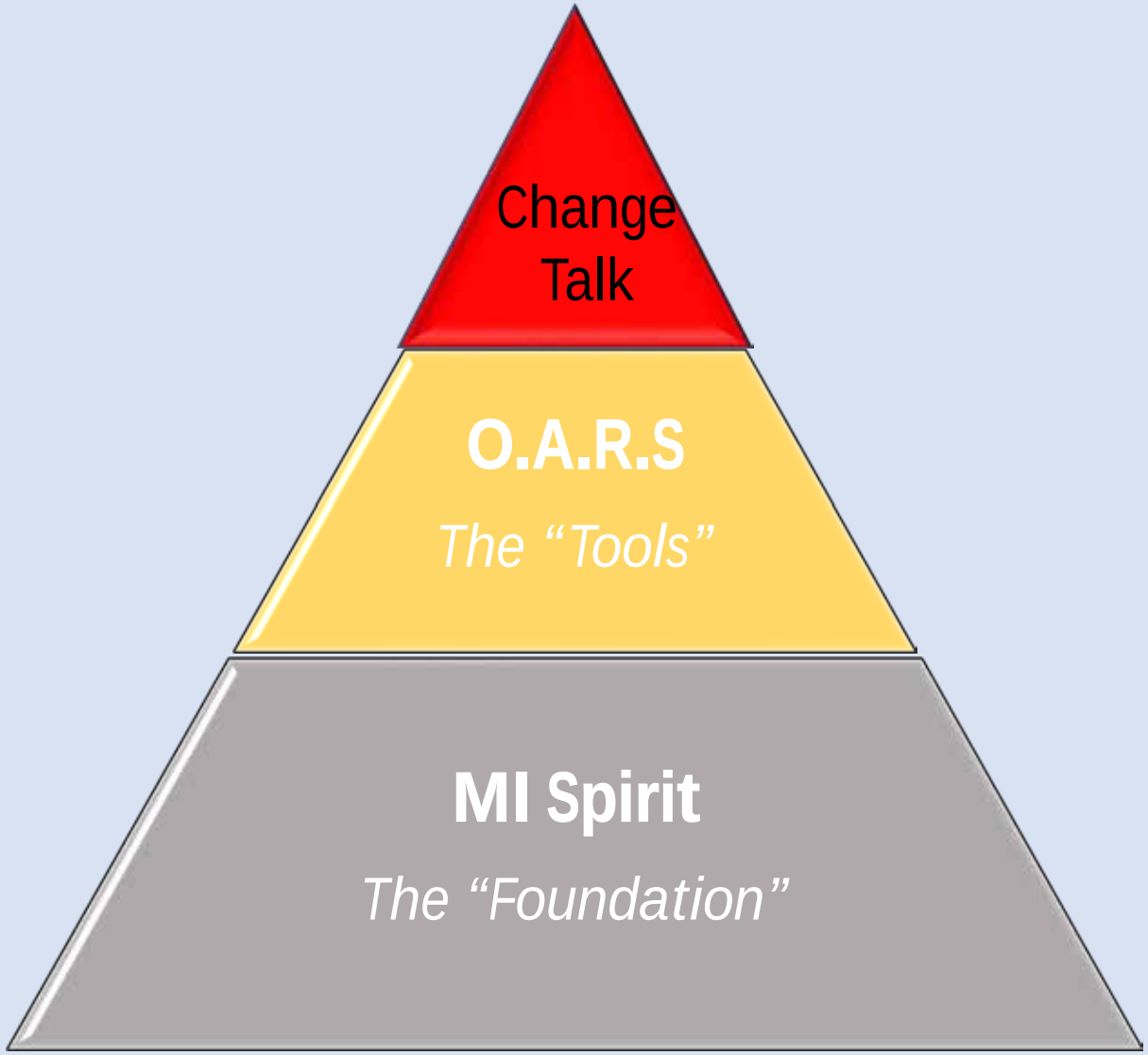
Reflections

OARS | Summaries

- Organizes experience
- Builds shared understanding
- Can be used strategically to advance change talk

The Outcomes of MI

- Resolves Ambivalence
- Elicits & Advances Change Talk
- Leads to Goals & Planning
- Creates Patient-Centered Treatment Plan
- Improves Health Self-Management

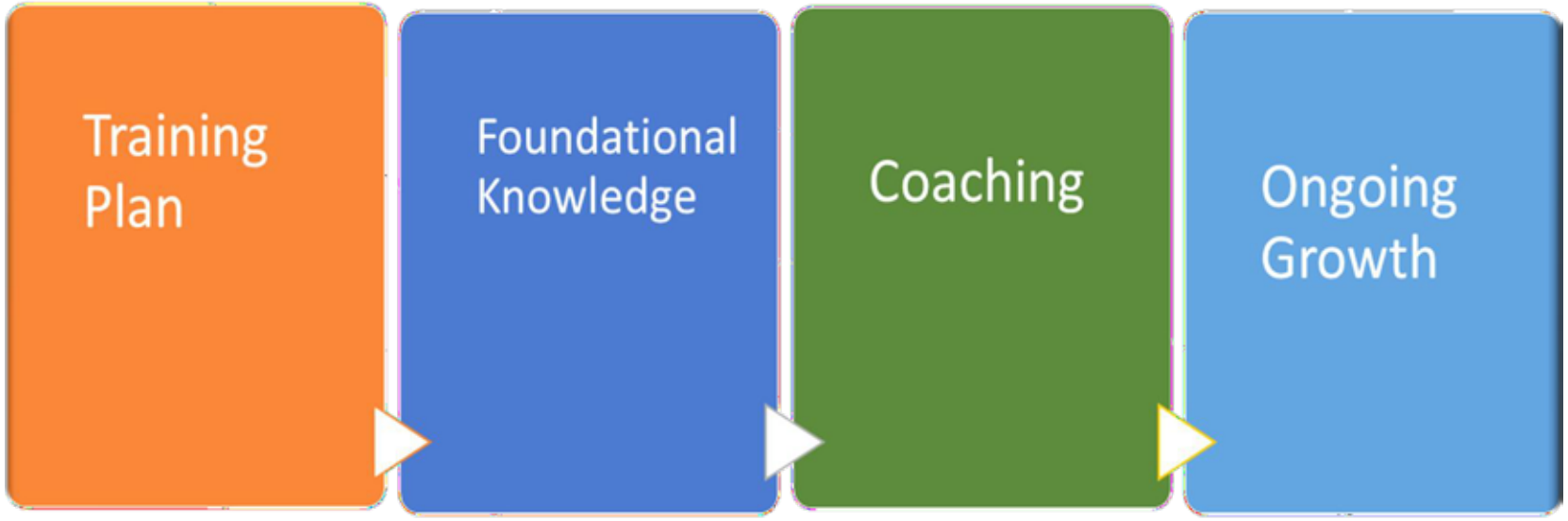


Case Study: Application of MI

Clinical Background	Patient Presentation	Instructions
42 y.o. female with cardiomyopathy **Clinical status:** Functional decline with EF 25% on maximal med therapy. Very engaged w/ meds, appts, weight loss attempts **Next step:** Pt. desires a cardiac transplant evaluation but needs to reduce BMI. Referred to bariatrics **Next steps:** Complete bariatric self-learning; schedule sleep study	**Chart Review:** Patient has not completed self-learning or scheduled sleep study **Telephone Outreach:** Routine weekly follow-up call for care management **Patient states:** "I'm feeling tired & worn down. I'm trying so hard, but dropping a lot of balls at home, with family and with my health management. I have to get back on track. I had been doing so well."	1. Write an **Open-Ended question** to engage the patient 2. Write an **Affirmation** based on information provided 3. Write a **Reflection**


ALRIGHT PEOPLE
LET'S DO THIS!
memegenerator.net

Integrating Motivational Interviewing

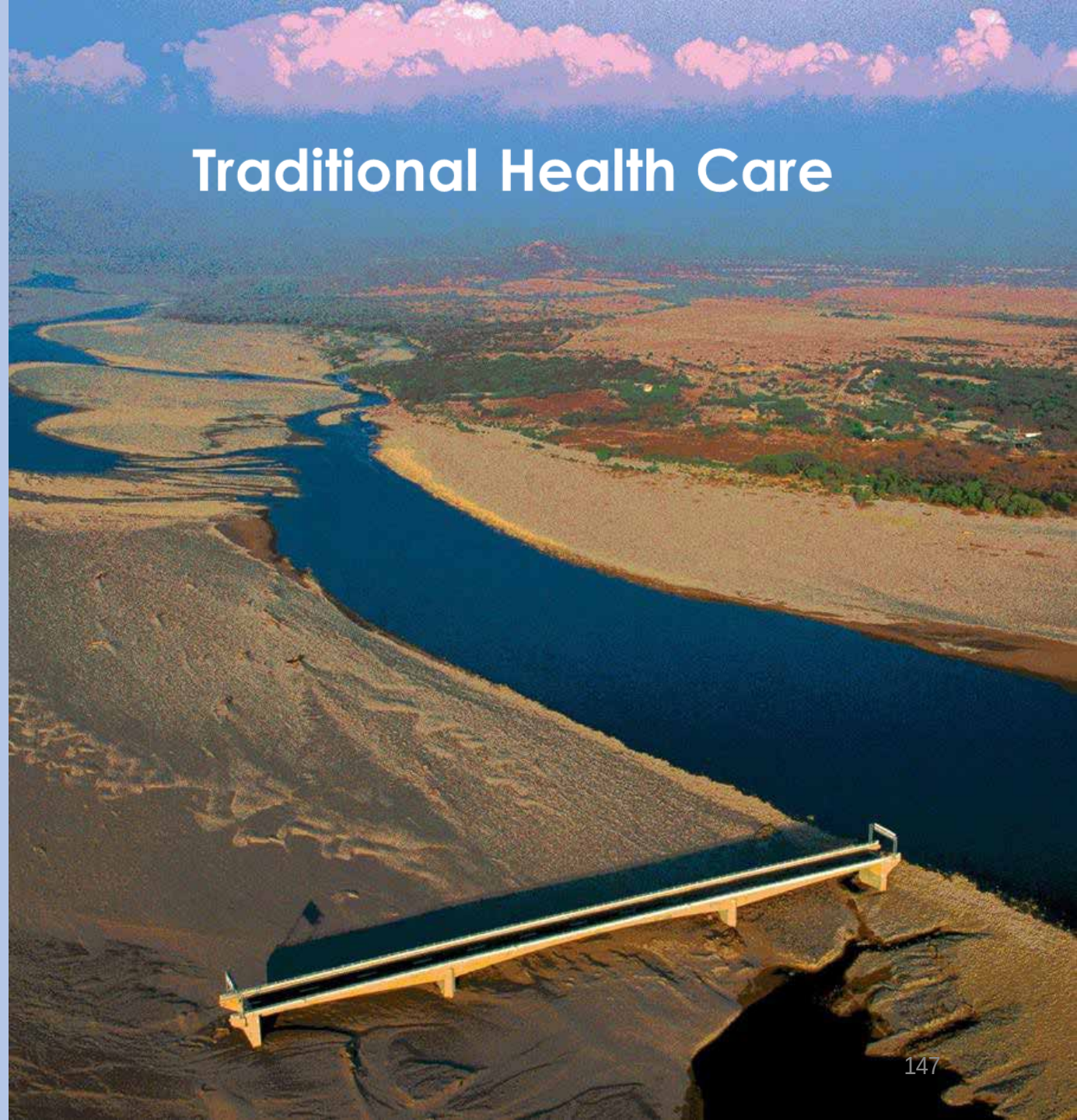


- Leader Training & Coaching
- Development of MI Champions
- Integration into Peer Review
- Competency Assessment
- Incorporation into Professional Development Offerings
- Practice Expectation

Outcomes

- Increased knowledge
- Skill development
- Increased TM confidence
- Clinical quality/excellence
- Improved Patient engagement
- Shift in culture

“Integrating MI into practice culture can be the bridge for delivering patient-centered care”



Questions?

Additional References and Resources

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Wisconsin Association for Healthcare Quality

Thank you!

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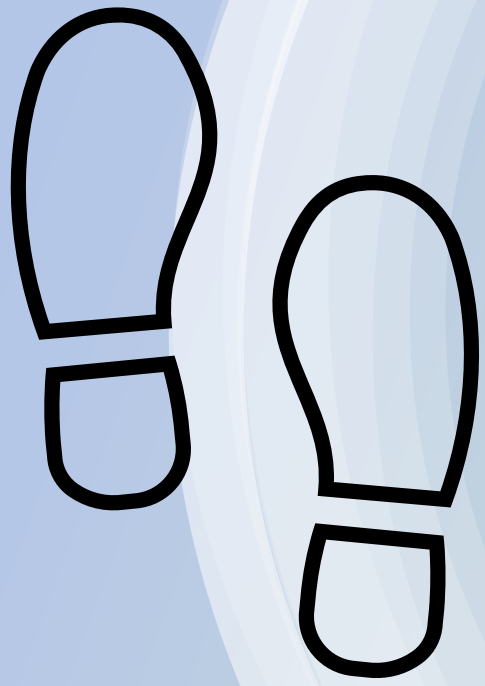

Break

Vendors & Storyboards Passport

WAHQ
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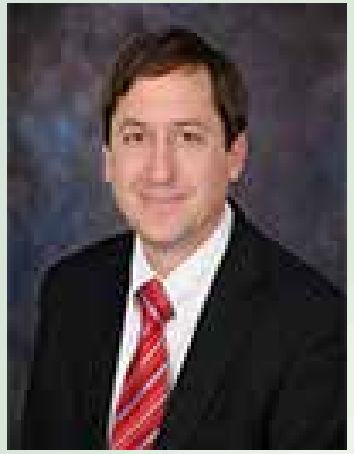
WHA Legislative and Quality Updates

Jill Lindwall, MSN, RN, CPHQ
Matthew Stanford, JD, MHA
Wisconsin Hospital Association



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Thank you!

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Evaluations
Certificate of Education
Passports Prize

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Thank you and be safe!