NATIONAL QUALITY FORUM

Report from the National Quality Forum: Second Quarterly Synthesis of Action In Support of the Partnership for Patients

April 30, 2014

Introduction

In 2011, the U.S. Department of Health and Human Services (HHS) launched the Partnership for Patients initiative in support of the National Quality Strategy priority and goals focused on patient safety. This initiative has emphasized collective action from both public and private sectors of healthcare to focus on two critical goals: reducing hospital-acquired conditions (HAC) by 40 percent and reducing preventable hospital readmissions by 20 percent.

Drawing on the 2014 quarterly meeting series, action team meetings, and other patient safety activities, NQF will produce a series of four quarterly reports that describe actionable, high-impact efforts in the field that are catalyzing and accelerating change. This report features three illustrative case studies from organizations that demonstrate exceptional results through collaboration and innovative thinking. This report is the second in a series of four, and focuses on activities occurring from February 2014 – April 2014.

Quarterly Meetings in Support of the Partnership for Patients

Both Partnership for Patients goals are multifaceted, complex and require strategic, ongoing collaboration and aligned actions throughout the healthcare industry. To reach these ambitious goals, HHS requested that the National Quality Forum (NQF) convene a series of quarterly meetings in 2014 to facilitate shared discussions about strategies for achieving the Partnership for Patients goals. The intent of these meetings is to foster shared commitment and renew or invigorate high-leverage activities on the part of participants to achieve the goals. The second quarterly meeting, "The Power of Alignment: Engaging Purchasers and Payers to Accelerate Patient Safety Efforts," took place on April 24, 2014. Approximately 27 participants representing purchasers, payers, plans, patients and other healthcare organization came together to identify and spread best practices for improving patient safety through their healthcare purchasing practices.

This meeting's agenda featured several purchasers and payers in action to improve patient safety. For example, the **St. Louis Business Area Health Coalition** is an active contributor of the **Midwest Health Initiative's Regional Health Improvement Coalition**, a forum to bring together purchasers, payers, providers, patients and others to share information and responsibility for improving the region's health and healthcare. In the last three years, members of this forum have taken action to improve maternity care, establish a website to educate the public about healthy living, and encourage appropriate utilization of emergency room services.

This meeting also featured **Intel Corporation's** innovative purchasing model that incentivizes providers to deliver high quality care at lower costs, with easier access to services, and **CareFirst's** Patient Centered Medical Home Program, a targeted program for members with significant illness burden that has contributed to a significant reduction in healthcare spending and readmissions.

Quarterly Spotlight
US Office of Personnel Management

With an insurance portfolio of 8.2 million members spread across the lifespan—including retirees, active employees, and dependents—the **Office of Personnel Management** (OPM) is taking the lead on purchasing high quality, consumer friendly, affordable insurance products for its members from birth to retirement. The OPM portfolio includes 97 carriers and 256 plans in three categories: the national government plan, employee organization sponsored plans, and comprehensive medical plans. By leveraging the size and purchasing power of this broad group of members distributed across geographical and demographic categories, OPM is driving quality and improving patient safety.

Through their four-part quality framework of quality monitoring, scoring, recognition and public reporting, OPM identifies and incentivizes high-quality care across their broad insurance portfolio of healthcare plans and carriers. In recent years, OPM successfully targeted several key patient safety areas through this framework, including early elective delivery, never events, inappropriate antibiotic use, and all-cause readmissions. Looking forward, OPM plans on building their lifelong relationships with members, improving care through accountability, and focus on drug utilization management.

The next meeting in the 2014 Patient Safety Quarterly Meeting Series, in July 2014, will focus on accreditation and certification efforts to reduce HAC's and readmissions.

Authentically Engaging Patients and their Families

In support of the National Quality Strategy, and to advance the Partnership for Patients goals of decreased hospital acquired-conditions and decreased hospital readmissions, NQF has convened a team of patients, patient advocates, providers, purchasers, payers, and other experts to drive person-centered care through system change. NQF's action team supports the Partnership for Patients Patient and Family Engagement metrics with its emphasis on authentic partnership, identifying and spreading best practices, and integrating the patient voice inside the system in a real and meaningful way. Organizations represented on this action team and with whom it collaborates are exemplars of authentic partnership between patients, families, care teams, and organizations at the system level in promoting person-centered care and increasing patient safety outcomes.

Vidant Health System in Greenville, NC has gone through a ten-year process of changing its organizational culture to be truly patient-centered. This includes every level of it organizational ladder, support staff as well as clinicians and governing body, so that each person knows they are respected and valued. Its REAL (Respect, Engage, Ask, Listen) DEAL (Dignity, Educate, Acknowledge, Learn) program is a system-wide model that promotes partnership at all levels, in every decision across the organization—including patient portal design, the creation of safety rounds liaisons, vendor selections, outreach programs, and leadership interviews. The results of the REAL DEAL have been significant and concrete—Vidant now performs in the 95th percentile on core quality measures; it has tripled the number of patient-family advisors inside its system; and it has reduced the number of its hospital-acquired infections by 58 percent.

Good Samaritan Hospital in Kearney NE has had an ongoing partnership with **Planetree, Inc.**, a consumer healthcare organization dedicated to humanizing healthcare, for over twelve years. Among Planetree's ten core

components that Good Samaritan has embraced is the Care Partner Program, which provides an opportunity for loved ones to be involved in safe patient care. A care partner can be a family member, friend or volunteer selected by the patient to participate at various times in education, physical, psychosocial and spiritual support of the patient. As a team member, the care partner is empowered to learn, to know and assist in daily cares, and to help with effective discharge planning. The Care Partner Program affects patient safety outcomes by improving communication, patient advocacy, quality and safety, and patient adherence to the treatment plan.

Kaiser Permanente is focused on using patient experiences to improve outcomes, and it takes a holistic organizational culture perspective to reach this specific end. One way it demonstrates its culture of workplace integration and communication is through an innovative "shadowing" program that allows non-clinical staff to interact with patients and clinicians to share ideas and understand each other's experience. For instance, Kaiser staff whose jobs are in the digital and tech world get to interact with doctors, nurses, and patients and then blog internally about what they've learned. This not only helps them understand what the technology needs of its clinicians are, such as how doctors would like to follow up with patients after a visit, but it gives them a sense of efficacy as they see how their role is connected to the overall vision and purpose of the organization—staying healthy.

Engaging Parents as Partners in Care

Some organizations have had a particular focus on increasing the role that parents have in their child's care, giving them a clearer voice inside the healthcare system, and empowering them with resources and education.

- The Parent Advisory Council and the Emergency Department staff at **Mattel Children's Hospital** in the **UCLA Health System** developed a patient passport that focuses on their high-risk pediatric population. The passport lists what service the child is receiving, their diagnoses, additional problems, drug allergies, and other considerations. It has been reviewed by all of the hospital and specialty staff, including the physician in chief, and incorporated into the ED system to prevent infection and other complications, to improve communication between families and care teams, and to increase transparency and coordination among all parties involved in the child's care.
- **The National Institute for Children's Health Quality (NICHQ)** believes that everyone benefits when healthcare professionals and families work together to improve care, and has developed a variety of tools and strategies to help parents navigate and manage their child's care. For parents of newborns who are going through a hearing screening process, NICHQ supported family leaders as they created a Parent Roadmap that graphically displays the steps involved in screening, as well as a timeline. They collaborated with the National Parent Chair for Newborn Hearing Screening to develop a Parent Survey on Experience of Care to allow for feedback on potential areas of improvement. Parents have developed an "All About Me" web page, as a communication tool for personalizing a clinical encounter, to remind providers that the child is more than a diagnosis. NICHQ has also supported the development of support groups, care plans, health literacy tools, care notebooks to help parents track their child's health, communication tools for parents to use with schools, and many other resources. In the words of one of these parents, "This was one of the most empowering projects I'd ever worked on because . . . my voice was an equal one. I felt like I was really helping to make changes in areas that had been big problems for me and my child."[1]
- In 2011, **Goodwill Industries, Inc.** launched an Indiana statewide branch of the national non-profit, **Nurse-Family Partnership**. NFP focuses on linking nurses with low-income, first-time mothers, improving pregnancy outcomes, helping parents learn how to provide responsible and competent care for their children, and offering assistance that will lead to improvements in the family's economic self-sufficiency.

The nurses make weekly or bi-weekly home visits until the child is two years old. A recent study projected that NFP's outcomes translate to a 56 percent reduction in emergency room visits for accidents and poisonings, 48 percent reduction in child abuse and neglect, 46 percent increase in the father's presence in the house, [2]an average of $23,485 in savings per family, with 55 percent of all savings accruing to Medicaid.[3]

Patient and Family Engagement at the Health System Level

One large healthcare system with significant patient and family engagement efforts is **Hennepin County Medical Center** in Minneapolis, MN. Hennepin experienced a change in governance in 2007, and used the opportunity to re-evaluate its processes and values. It surveyed over 1,800 people and the overwhelming response elevated Patient- and Family-Centered Care as the top priority. Leadership has acted in a variety of ways, through new program development, system redesign, and active seeking of patient feedback, both positive and negative. One significant way leaders have responded has been to place patients and family members on organizational committees. All candidates for executive level and chief positions include an interview panel with at least one patient; last year, a 20-patient panel interviewed the new CEO. Hennepin also hosts a 3-day boot "experience rally" with 3,500 staff and 500 patients, designed to inspire, inform, and empower them with the knowledge and skills needed to put Patient and Family Centered Care principles into practice. Patients and families are invited to share their stories in panels and small groups with staff. Post-event surveys reveal that staff have a newfound appreciation for how their words and actions impact patients and families, and patients and families express a stronger desire to understand and take control of their own care.

Beth Israel Deaconess Medical Center (BIDMC) in Boston, MA is partnering with the **Gordon and Betty Moore Foundation** to reduce medical, emotional, and mental harm experienced during their hospital stay, specifically in the ICU. Toward this end, they have developed an interactive myICU app to help patients and families have easy access to their care team and vital health information as well as provide input on their care. **BIDMC** also is partnering with **The Conversation Project,** an initiative of the Institute for Healthcare Improvement (IHI), to be "Conversation Ready". This partnership reframes the patient-provider relationship around the question, "What matters most to you (the patient)?"

Improving Maternity Care

The Maternity Action Team continues to promote healthy mothers and babies by further reducing early elective delivery (EED) rates, prior to the 39 weeks gestation, to five percent or less in every state and US territory. Three high leverage strategies have been identified with a major focus on measurement, partnership, and communication. Maternity Action Team members and other stakeholders are already in action to support this aspirational goal.

For example, the **Carolina's Healthcare System** (CHS), a hospital engagement network that offers healthcare and wellness programs throughout North and South Carolina, has achieved significant reduction in EED, from 4.07 percent in January 2012 to 1.72 percent in October 2013. The hospitals accomplished this through a number of strategies, such as engaging their providers to build relationships, educating data collectors on perinatal core measure abstraction, implementing a hard stop policy, and educating patients about expectations based on **The Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN)** *"Go to the Full 40"* campaign.

Maricopa Integrated Health System, Arizona's only public healthcare system, has eliminated EED entirely – to zero percent – since 2013. This outstanding achievement was accomplished through implementing a strict hard

stop policy, redesigning their labor and delivery scheduling form, and patient education with new tools. A key strategy of the health system was that all clinicians were employed by one entity, District Medical Group, which facilitated an environment in which they function as one unit. They also maintained a commitment to quality indicators by having an OB quality and research committee, in addition to several other perinatal performance improvement committees.

Quarterly Spotlight

South Carolina Department of Health and Human Services

In 2011, **South Carolina's Department of Health and Human Services (SCDHHS)** initiated the Birth Outcomes Initiative (BOI) to improve health outcomes for newborns in the Medicaid program and throughout the state. The BOI has three interconnected goals to improve birth outcomes, including: 1) Reduce the number of low birth weight babies; 2) Reduce NICU admissions and stays; and 3) Reduce racial disparities in health outcomes.

Through the BOI, SCDHHS engaged more than 100 public and private stakeholders, including upfront engagement of physicians, and relied on data collection and monitoring as an integral factor in the initiative's success. Through this initiative, SCDHHS (which administers the state Medicaid program) partnered with the largest local commercial insurer, **Blue Cross Blue Shield of South Carolina (BCBSSC)**, to adopt a non-payment policy for EED. Between SCDHHS and BCBSSC, they cover 85 percent of all births in South Carolina, and became the first state in the country to establish consistent payment policy through public-private partnership. As a result, across all payers, the EED rate dropped from 9.62 to 5.24 percent, representing an almost 50 percent decline from Quarter 1 of 2011 to Quarter 1 of 2013.

Source: Catalyst for Payment Reform Case Study of South Carolina Birth Outcomes Initiative

The Florida Perinatal Collaborative, a coalition of statewide partners committed to improving maternal and infant health outcomes, and the **Florida Hospital Association**, through the **Health Research & Educational Trust Hospital Engagement Network,** are working together to further reduce EED in Florida. Together, these organizations are using the March of Dimes toolkit to assist participating hospitals in reaching this goal. The state has expanded efforts to reduce non-medically indicated deliveries before 39 weeks through a number of avenues and discussed several challenges, including funding, intensity of quality improvement efforts, changes in data reporting, and preventing recidivism. It has also launched a three year education and communications campaign to sustain long-term change.

Community Care of North Carolina is working with the **North Carolina Division of Medical Assistance**, and the **North Carolina Division of Public Health** to develop a program designed to provide comprehensive, coordinated maternity care to pregnant Medicaid patients. The Pregnancy Medical Home (PMH) Program began implementation in March and obstetrical care providers are supported by the partnership to increase access to care and improve birth outcomes for pregnant Medicaid recipients. More than 300 practices and clinics have signed contracts to become a PMH. By participating, maternity care providers receive financial incentives for risk screenings and evaluations, as well as ongoing support from a pregnancy care manager and the local CCNC network. In turn, practices agree to work toward quality improvement goals, including reducing EED prior to 39 weeks.

The American College of Nurse-Midwives, Midwives Alliance of North America, and **National Association of Certified Professional Midwives** developed a consumer-friendly factsheet entitled, *Normal, Healthy Childbirth*

for Women & Families: What You Need to Know. This guide offers critical information to help women make informed decisions and avoid potentially unnecessary and expensive medical interventions.

The Joint Commission is developing a new optional certification program for accredited organizations that will focus on high-value requirements for low-risk mothers and newborns. The Perinatal Care Certification will be based on an independent evaluation of an organization's prenatal, intrapartum, and postpartum care services, while more fully addressing all stages of this specialty service.

Reducing Preventable Readmissions

To complement the Partnership for Patients goal of reducing hospital readmissions and the many efforts focused on improving care transitions from the hospital setting, NQF's Readmissions Action Team is focusing on leveraging patient, provider, and community partnerships, and on identifying and addressing patients with psychosocial needs. These strategies include working together across stakeholder groups to enhance systems improvement, collaboration, and patient and family engagement. Below are noteworthy efforts by action team members and organizations with whom these organizations partner to reduce avoidable readmissions and readmissions in complex patient populations.

Medication: Involving Pharmacists in Care Transitions

America's Essential Hospitals (AEH) is working with its member hospitals to reduce readmissions, specifically focusing on increasing the involvement of pharmacists in care transitions, beginning in 2012. The following are three examples of AEH hospitals that have achieved significant results from working more closely with pharmacists.

- **Alameda Health System** in CA does screenings for high-risk patients and follows a number of steps to provide further clarity, communication, and support for these patients. First, the pharmacist meets with patients prior to discharge to discuss their medications and to do a reconciliation to check for possible errors. This includes a teach-back system to educate patients about how to use their medications. Second, they provide a minimum 30-day supply of medication to provide initial stability upon transitioning out of the hospital. Within 24 hours of discharge, the pharmacist calls patients to check in, and makes a home visit within 2 weeks. Further, they connect patients to their primary care doctor or an Alameda clinic, and make sure the clinic addresses social needs such as transportation, housing, insurance, etc. As a result of this significant effort to overcome the transition barriers that patients face upon discharge from the hospital, they've seen a 12 percent decrease in readmissions since the program started.
- **Santa Clara Valley Medical Center** in CA similarly arranges a patient-pharmacist conversation in the hospital before discharge for their high-risk patients, and within 2-3 days post-discharge, the pharmacist calls the patient to screen for issues. The program is expanding to place clinical pharmacists in discharge clinics for patients who do not have a primary care physician. Santa Clara Valley has reduced their readmissions by 5 percent in the first year of program implementation.
- **Truman Medical Center** in MO is targeting heart failure and COPD patients through EMR screening. The pharmacist sees the patient within 24 hours of admission to the hospital and is involved in teaching, verifying the home pharmacy, and doing medication reconciliation. The pharmacist also does post-discharge phone calls within 3 days to screen for issues and sets follow-up appointments with either the primary care physician or a clinic in the area. Results show a 10 percent decrease in readmission rates.

Readmissions Studies and Data Gathering

A number of organizations are focused on understanding root causes of preventable readmissions, collecting data, and sharing this with partners to spread the knowledge that they are gaining. **Janssen Pharmaceuticals**, for example, is exploring the direct costs of schizophrenia and available treatment options through a research project focused on the cost of relapse, delaying time to hospitalization, and continuity of care across clinical settings. **Geisinger Health System** is working in collaboration with other leaders in health services including medical management, pharmacy, quality improvement and wellness teams to build a comprehensive population health approach focused on patient engagement, care coordination and overall case management. Geisinger also is gathering data on reasons for admission, readmissions by diagnosis, age, and population. **Select Medical** is compiling literature reviews on psychosocial factors and hospital readmissions, and **Kaiser Permanente** is collaborating and partnering with senior leaders and regional clinical leads to help monitor specific readmissions metrics on a quarterly basis.

Community Interventions

There is broad acknowledgment that in order to address the problem of preventable admissions and readmissions, certain socioeconomic, psychosocial, and population health-related issues need to be addressed also, especially for vulnerable populations that may have chronic health conditions or those who lack social supports.

Quarterly Spotlight:
Preventing Hospital Readmissions in the Home and Community

Bronson Methodist Hospital (BMH)'s nurse-practitioner-led Care Transitions Coach Program demonstrates coordination across the continuum of care by engaging patients, family members, and their caregivers in the home setting.

The aims of the Care Transitions Coach Program are to provide disease or condition-specific education and self-care behavior management skills. It starts by offering resources and support for patients and their families for medication reconciliation and early medication intervention after discharge. There is a focus on patient and family understanding and empowerment, while encouraging and coaching patients to develop effective relationships and communication with their outpatient healthcare provider. The Care Transitions Coach Program aims to coordinate patients' care and help them navigate the healthcare system, supporting them in transitioning from the inpatient setting to their next care setting. Creating a face-to-face handoff to the next healthcare setting (e.g. home, nursing home, etc.) has proven to be a key factor.

After the first year of implementation of the Care Transitions Coach Program, the 30-day readmission rate for patients enrolled in the program fell from 20.3 to 9.6 percent, with another reduction of 4.4 percent for enrolled patients after two years. This began as a pilot program serving primarily the heart failure population, but Bronson has since expanded to other adult patients at high risk for readmission to the hospital, particularly those with chronic conditions.

Maine Medical Partners has developed a program, "CrEST" (Creating, Effective, Sustainable, Transitions), whose premise is that providers need to match the level of intervention to the level of risk to create a stratification system for each patient and identify high-risk patients based on a comprehensive assessment of clinical, social, and financial risk. The CrEST program addresses issues in the patient's life such as adverse childhood experiences, relationships and trauma, and social determinants of health. It promotes a complete care team and support system for the patient and individualized interventions. The outcomes of the CrEST program have been a reduction in cost of $19,630.97 between the baseline and first year of interventions. One individual case study showed a 33 percent reduction in emergency department visits in 10 months and another prevented 4.6 admissions over 64 days.

NQF Look Forward to Activities in Support of the Partnership for Patients in Quarter 3

Looking forward to the next quarter, NQF will convene each Action Team for a second round of in-person meetings in June to discuss progress, sustain momentum, and further their goals as they finalize their Action Pathways. Each action team will also have the opportunity to present their goals and strategies in a series of public webinars in July. The third quarterly meeting in the 2014 Patient Safety Meeting Series, also in July, will bring together key stakeholders to leverage accreditation and certification efforts to accelerate patient safety. Finally, the third quarterly impact report will be completed by July 31. Materials for all past and future events are available on NQF's website.

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[1] http://www.nichq.org/documents/powerful%20partnerships.pdf
[2] http://www.goodwillindy.org/mod/aboutGoodwill/nurse-family-partnership/
[3] http://www.nursefamilypartnership.org/assets/PDF/Communities/Indiana-Documents/Goodwill-Whitepaper-Feb-2014.aspx