Good afternoon, everyone. Thank you again for joining us. We are really, really excited about this program, and we’re absolutely delighted to see so many of you on the call today.

So the call today really is an introduction to the CMS Partnership for Patients initiative and specifically the New York State Partnership for Patients, which is a joint partnership of the Healthcare Association of New York State and the Greater New York Hospital Association.

As (Inaudible) said, my name is Kathy Ciccone, and I serve as Executive Director of HANYS Quality Institute and private co-Director with my colleague, Lorraine Ryan, from Greater New York. We both have several people in the room with us, but the other speakers on the phone today are really the real leads of our program, and that would be Nancy Lander and Zeynep Sumer-King. But of course we both have other staff with us who will be happy to answer any questions as they come up.

We really do appreciate the enthusiasm. We have heard from so many of you who are interested in getting started on this work, and we’re absolutely thrilled that we can be responsive to that.

Let’s back up just for a moment. I know there’s a lot of new staff who are on the phone today although we had about 170 hospitals participate with the Partnership for Patients, there are new staff and also some hospitals who perhaps participated with others maybe on the call. I just wanted to mention CMS Partnership for Patients is a national quality improvement project and campaign. It’s sponsored by the Center for Medicaid and Medicare Services, and the goal, really, is to work with hospitals across the country to address the national goals of reducing preventable hospital acquired conditions and preventable readmissions by 20 and 40% respectively from the 2010 baseline. And to do that through the reliable application of evidence-based practices.

The first effort was a three-year effort ended last December. We call it the Hospital Engagement Network 1.0, or HEN 1.0. It involved 26 Hospital Engagement Networks who carried out the work across the country with hospitals around recruitment, education, technical support and data analytics.

Nancy, I’m still on my first slide.

We’ve eagerly been waiting for CMS to make decisions about continuing the work, and we’re very happy to sort of officially kick this off today. So today’s webinar really, and the agenda is up here now, is intended as an introductory call. There are lots more conversations to come. But to give you a brief overview of what’s entailed in the new HEN 2.0, to talk about the goals and the topics, much of the details are that are specified in the CMS contract, but there was opportunity to tailor our approach and our delivery for the New York State hospitals. We really enjoyed working with you in the past, and we took a lot of what we learned from you, we built on the key themes about what works best and some of the new areas you identified for focus, and Nancy and Zeynep will talk about that going forward, measurement and analytics are, of course, continue to be an important part of the program, and we will continue to draw from existing data whenever feasible.

And finally, it’s never done until the paperwork is done, and in this type of contracting world, it never begins until the paperwork is done. So finally because this is a new initiative, there is some paperwork that needs to be completed by our participating hospitals, and we encourage you to complete that as soon as possible and particularly for signing up and letting us know who the key contacts will be in your organization. We’re going to emphasize this point a few times because we really do want to move forward as quickly as we can and we need some of that information.

Next slide, please.

So this is kind of old news now. CMS last week announced the Partnership for Patients. It was a very competitive process, and we are fortunate to be one of the 17 HENs that were approved in the final selection process. We really believed that, you know, we had a strong proposal, but we know full well that we were approved because of the great work that our hospitals did in the project and this incredible
achievements that you made with regard to some of the topic areas that were addressed around preventable harm and readmission in the last effort. So the focus really is on, you know, several key dimensions. Some of them are the core topics that we addressed in the past. But also there is a much broader focus on harm across the board. So a stronger focus on patient and family engagement. And then there are selected new priority areas, so in addition to the core topics that we addressed in the last round, we also have some new clinical priorities, many of them ones that we selected, and actually there’s only a few, are consistent with the work that we’re doing in our state.

And then, of course, there’s a deeper dive into the data and analytics. We had a call with CMS the other day, and tremendous focus on being able to, I think, more clearly articulate some of the harms avoided, some of the cost savings that are directly attributable to the Partnership for Patients work.

So this is my final slide and I’ll turn it over to Lorraine. But this is a 12-month engagement. You may remember the last engagement was two years and then CMS extended it for another year. We welcome all hospitals in your state to join the Partnership. I know that we’ve have some hospitals who participated with a different Hospital Engagement Network in the past and they have asked if they can enroll, and of course we’re happy to work with all of our member organizations.

And, again, the enrollment checklist, asking you to please take a look at the material. If you have any questions at all, please don’t hesitate to contact us. And as soon as it is feasible for you, if you can send that back to us, we would very much appreciate that.

If I could turn it over now to Lorraine Ryan.

Hi, Lorraine?

I’m here. Thank you, Kathy. I think my line is open.

I, too, welcome all of our hospitals on the line today, and on behalf of the Greater New York Hospital Association team, we’re delighted to be able to bring you another year of the Partnership for Patients. As you look at this graph, which really details the tremendous success over the last three years, give yourselves a pat on the back because this is your success. These are your achievements, and we would not have been chosen for a fourth year had it not been for the tremendous efforts of our hospitals. And to those of you who may be new to the /New York State Partnership for Patients, this is what you have in store for you and your organization, a tremendous opportunity to really improve across the board to reduce harm for all patients in all service lines and to ensure that they have a quality experience.

You’ll see on the left side of this graph the actual numbers in terms of the achievements of approximately 30,000 injuries or complications were avoided as a result of this effort. This is the New York State effort. There’s a much larger achievement across the country, as you know. But over 1,800 fewer early elected deliveries, and we’re seeing tremendous sustainability in that area along with reduction in readmissions. And we all know how difficult it is and how complex reducing readmissions is, but, again, we’re hoping that this future year gives us another opportunity to sustain those tremendous gains. We also saw tremendous improvement with CLABSIs.

It’s almost all good news. We do have a ways to go with regard to surgical site infections, specifically around colon. But even there we’re seeing, you know, an uptake in the evidence-based practices that we know will ensure improved outcomes. And we have some work to do in DTE.

And despite this tremendous improvement, we still have a ways to go in terms of performance. So this next year gives you that great opportunity to really help move your organization along.

And if you can go to the next slide, please.
I just want to point out, you know, putting the Partnership’s work in context, in many ways the lessons that we learned from this initiative have much broader application as we sort of move into the new frontier of an emerging and broader quality landscape. The imperative to change culture, the focus on patient experience and engagement, team-based care, which is where it’s at and what we will need to be able to create in order to ensure that sustainability in outcomes, and the fidelity to evidence-based practices are all essential to these emerging programs. So whether it’s DSRIP, the Delivery System Reform Incentive Payment Program, the State’s Health Innovation Plan, or Transforming Clinical Practice initiative which was focused very much on individual physician practices, all of these themes will run throughout those initiatives. So what you’re doing on the inpatient side, and the Partnership is very much focused in the acute care setting, is very relative, pertinent, and will be very valuable to those initiatives that are more outpatient focused.

At this point we’re going to move into what is HEN 2.0 all about. We’re going to take about 40 minutes to take you through the new areas of focus, along with those that we will continue to focus on from the first three years, and the Partnership’s approach to ensuring that this is both valuable and meaningful to you and your staff. And to begin that discussion, I’m going to turn the mic over to Zeynep Sumer-King from Greater New York.

Thanks, Lorraine. Good afternoon, everybody, and thank you for joining. We’re so excited. I’m going to start this off on talking about the /New York State Partnership for Patients approach, but Nancy’s really going to get into the – drill down and get into the detail of it, and then I’ll pick back up and talk to you a little bit about measurement and tracking. As Lorraine said, we’re going to try to get through this not in 40 minutes, but in 30 minutes so that we can leave some time for questions. And we do want to hear from you. We want to hear all your questions, even if we can’t answer them, we want to go searching for the answer and get back to you. So give us your thoughts.

So this slide you have up now shows you the areas of focus that CMS has identified for HEN 2.0. The darker-shaded boxes are the topics that we focused on over the past three years. They’re very familiar to you. But if you look back at the slide that Lorraine was speaking to just a few minutes ago showing our improvements and areas of opportunity, we still have an opportunity for improvement in almost all of these areas. There are – if we have not met the 20/40 goals, we’ve met some improvement goals, but we still have some ways to go before we can say our job is done. And, in fact, while we’ll be focusing on each of these topics, we’ll be looking at it more holistically, more systemically, and hopefully that will not only bring down rates in all of these areas, but will hopefully also have a kind of halo effect on your other clinical priorities throughout your hospital.

The lighter-shaded boxes, starting with delirium there on the right, are new topics for HEN 2.0, and perhaps they’re priorities for your institution already, and we’d love to learn from you if they are and share statewide best practices. They include delirium, C. difficile, a topic we’ve looked at across New York State and that New York State is tracking and very focused on as well. Linked to C. difficile we’ll also be addressing antimicrobial stewardship, both HANYS and Greater New York have robust and complementary programming going on around antimicrobial stewardship. We’ll be making linkages to those programs and continuing with measurements that’s complementary. And also focus not just on C. difficile but also MDROs that you are impacted by.

Sepsis. Sepsis is not new to New York State, but we certainly still have some opportunity for improvement there, especially in the adherence measures, and especially because we’re all, as an industry, now transitioning to reporting to CMS as well as New York State to reduce the burden on all your sepsis-related activities and to really align with what you’re already focused on, we are partnering with the Department of Health and IPRO. We’ll talk a little bit more when we get to the measurement slides about data collection, but we really do think New York State is ahead of the curve in its thinking in terms of areas to address, and we’ve already started those discussions, both HANYS and Greater New York, with all of you. We’ll continue them through this effort.

Additionally, CMS would like HENs to focus on health disparities and opportunities to address disparities as they impact your hospital’s (inaudible) conditions. And while patient and family engagement was a
theme throughout the previous years, it is a formal requirement that HENs must address, and hospitals must address in this round.

Next slide.

So Kathy already mentioned the goals. They are the same, 40% reduction in hospital acquired conditions, 20% reduction in readmissions as compared to 2010. This is the same goal, same benchmark – I’m sorry, baseline – as our previous work that we’ve done with all of you, so we’re just continuing and hopefully picking right back up where we left off. Additionally, though, CMS is looking to get insight into some other areas. So cost savings and quality. This is out of the – I’m now blanking on the new name of this office that’s formerly known as CMMI. They are all about innovation and the triple aim, which includes cost savings in healthcare delivery. We – again I’ll talk a little bit more about what that entails in terms of measurement later on, but we will be getting requests from CMS with respect to cost savings related to the specific clinical topics and overall improvements that we’re making.

Health disparities I mentioned as an area of focus, and interventions in the previous slide. But here it’s really – CMS would really like for hospitals to think about how they can capture real data, real disparities data in a more efficient and accurate fashion. Race, ethnicity, age and language real data. And this is also – we know this is a priority for CMS because it shows up in all their programs. It’s also a priority for New York State. And we’ll be talking to you all about strategies for how to better capture that data, whether it’s through your electronic health record, during registration, or some other best practices.

And then lastly, and CMS emphasized this last point pretty heavily the other day when we were on a call with them. They’re looking at pediatrics and addressing challenges in improving pediatric care. We’ll be looking at how we might be able to address this in the future, but this seems to be an emerging theme for CMS at least as of this week since we’ve been awarded the contract.

I’m going to turn it over to Nancy to take us through the approach.

Thank you, Zeynep, that was great.

Okay. Basically what I want to see is that, you know, we’ve learned many, many things from HEN 1. We’ve learned things at a state level and at a national level. And we really gained a lot from your input and ideas. So those all helped to frame where we are at this point. And where we’re basically going is is that the very big focus is do no harm across the board, which you hear about, I mean you’re hearing it from CMS at about every single venue. They frequently are framing it like nobody wants to go to a hospital that’s only good at some things. You know, you get that tone. However, the reality is is we’re framing no harm across the board, but we tend to take a look at it more from the fact that there’s so many initiatives going on, and it really is more important and is vital to us to become more integrated in terms of our approach to addressing these things, and we also want to look at things that transcend fall prevention practices. So if there are things that we can strengthen in our hospital system, what are they that will have an impact on those prevention things we’re working on now and those even in the future. So we are definitely taking this no harm across the board approach, and you’ll see how that fleshes out when we get into tactics.

The second part of the major learning is that, you know, the frontline staff certainly drives improvement. And drive real change, and frankly drives sustainability. And so we all know in the literature, and we all know in New York State that the practices involving frontline staff, point of care in quality improvement is essential. They’re going to be highly successful at identifying the true root causes and particularly successful at dealing with the unique needs that are happening at their unit or department level. So the whole emphasis is really going to be on strengthening that.

I’m not suggesting in any way, shape or form that we’re expecting departments or nursing units to be Lone Rangers about their approach to quality improvement. I mean, obviously, they have to do that within
the hospital’s policies and protocols. However, I do think that the operationalizing and the improving of these kinds of programs at the frontlines is extremely effective and will serve us well.

The second part of that is that when we’re building this capacity at the frontline, it is something that will transcend all of our work. But an important component of it is also the culture in the hospital and the culture particularly in those units and departments. So you’ll see us addressing culture as part of this whole frontline staff across the board improvement.

Lastly, in terms of focusing on the frontline staff, we’re really going to be viewing some leaders and liaisons differently. It depends on what your system is, but we’re really not expecting the quality leaders and the liaisons to be the doer bees. We really are looking at them – all of you likely on the phone – to be leaders, facilitators, champions, trainers, coaches, or even consultants with the frontline staff. So for some of you that might be a very different approach where we’ve traditionally done a lot of teaching with you, we’re looking really more to partner with you to bring that to your frontline staff.

And lastly, the last biggest tenet, is really around sustaining reliable practices. We’ve talked about the fact that, you know, applying these things rapidly at the bedside is very effective, and having that bedside team involved from the beginning sort of has the end in mind already, so you’re, you know, making a leap into the future. But putting these systems in place really do meet a lot of criteria. And basically what you’re doing is you’re teaching your frontline staff how to do quality improvement and how to do prevention live. It’s interactive. It’s live. They’re right there doing it. And they’re implementing while practicing. And to be honest with you, let’s face it, medicine is an art and a science. And we’re no different than other artists or athletes and musicians. We need repetition and practice as well. And doing that kind of work on the frontline as part of your quality improvement is actually essential.

So, with that, with those tenets being said, what we’re going to do is take a look at all of our services within what we’re calling Patient Safety Hub. And there’s going to be five of them. Obstetrics will be pretty traditionally what you’ve been used to. Med Surg and Critical Care, I’m going to focus a little bit different in a minute on the tactics around those. And we’re going to reach out to the Operating Room or the Surgical Suite to take a look at, you know, what their role is in the advanced surgical bundle and working directly with them. And some things in the Emergency Room as well.

So we’re really moving very much away from an initiative based into a unit based approach. We’ll focus on some statewide education for some of the new areas and some of the creative programming that we have. But it really is a total shift in the kind of care.

So let me talk a little bit about what this means. We are seriously not doing statewide education in many, many of the initiatives. CAUTI, CLABSI, pressure ulcers, falls and DTEs. We believe that you all know the evidence. We know that in HEN 1 we brought the current evidence-based practice, and frankly most of the national leaders to New York State, and we have all that robust library for us to depend on that’s still very, very current. So there really is no point in repeating it. We have it as a resource that we can use more in Just In Time and when needed.

So for the Critical Care and Med Surg area, what we’re really saying to them, and almost exclusively for the Med Surg area, is our plan is to work with each hospital to develop and implement, or perhaps enhance as many of you may be doing this, a unit-based daily safety check in that goes on between the unit manager and the caregiver staff. That unit manager could be the nurse manager, could be the assistant nurse manager, could be nurse champions, nurse educators, patient safety nurse. I think that will be tailored uniquely to your needs and the caregiver staff, those that are caring for the patient, the RN, the techs, whoever, whatever your staffing plan is.

We want to look at daily safety checks in the way that they best meet your needs, how you’re organized. So I could talk to you about traditionally making rounds with checklists, and frankly we will have tools available for you to do that. However, the project managers really will look to what makes sense for the hospital. Some of you may already be doing this and already have checklists in place, which is fine. Some of you may have it partially done. Some of you may prefer huddle approaches, or briefing approaches.
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There’s a variety of ways that you can do this. But we will – but the main goal is to get daily safety checks going on between a leader and the caregivers.

Seven days a week. I know I’ve given this speech to a number of advisory committees and stuff to date, and I have people saying, well, make sure it’s done on the weekend, make sure it’s done on the evening shift, and I understand the importance of all that, but right now, in year one, we’re focused on rapidly getting it out on a couple of target units and then spreading it as rapidly as possible through the hospital. And then, you know, you can use your judgment if you want to expand it beyond that.

We will support that rapid spread in a variety of ways. And I want to take a little pressure off because – not the accountability part, but the pressure part – because doing these – implementing these rounds or safety checks or huddles or whatever you choose to do in your hospital is really about practice and repetition. It’s not about perfection. And, you know, some of the pressure can come off. Now do we expect that you’ll get excellent at this and efficient at this over time? Absolutely. That’s not what I’m – I’m not saying you won’t do that. But it’s really not about oh, you have to absolutely do this perfect. Because, frankly, just doing it, just like any other artist, it’s going to have lots of gains in terms of building capacity and education.

So the real way we are thinking about it is as this rolls out on the nursing units, Med Surg, it really begins really with awareness. And frankly if you can get awareness of all the prevention practices healthfully into the system, that’s great. You know, we always say an RN is never going to forget a medication or a treatment. But do they forget implementing every single prevention practice? Maybe. And it’s partially because it’s not intentional, it’s just part of human factors. It’s part of it’s not built into their daily work life, it’s not something that’s as much a part of who they are professionally, and we’re just trying to change that a little bit. So at first we practice and we work on getting the system efficient, and we build awareness. And we’ll get some Hawthorne effect out of that. There’s no question about it.

And then from there we’ll work with the nurse managers on those units to look at what kind of educational things might be appropriate for that unit. And we’ll target education, or we’ll target resources for the nurse manager or nurse educator to target education. And then once we get that baseline structure in place, we’ll support the frontline staff with quality improvement, which really includes sending project managers into the hospital to work directly with those units to provide whatever. Observation, support, coaching, whatever you feel is necessary.

So that is the essence of our approach, particularly in the Med Surg and the Emergency Room areas.

In the OR, in the ED, we have a safety checklist version but it’s a little bit different in the sense that obviously those services aren’t set up to do a whole lot of daily safety checks so we’re going to go at it a little bit of a different way, but it’s the same principle of looking at what are those key safety issues that should be in the forefront of their (inaudible).

So with that said, I’m going to go over some resources, but I’m going to go over this pretty, pretty quickly. Basically we’re going to look at support in the hospital leadership and the traditional ways we’ve done it. The dashboard, the summary report. We may even work with the leaders on going to some of these safety rounds and a variety of other things. We’re going to actually really promote or pursue getting hospitalists and pharmacists and intensivists more involved in some of the work because they are key and frequently not at the table as often as they can be. And we’re going to continue to do the ARC Culture 60. We’re going to do it next March.

Same with the clinical managers. We’ll bring our resources, our data, our PPR reports, educational programs. We have built gap analysis of strategic planning tools at the unit-based level. It’s not something that’s elaborate. It’s something that really even the project managers might even fill out with the nurse managers on the OR or the unit. But we will have those tools available to help us frame our work. And, again, lastly for the frontline staff, we will tailor the programs, the education, our resources and our project managers to do whatever they can to help you meet the needs.
So it’s really your opportunity, whether you’re thinking about what you want to do to really capitalize on the PFP for your system or for your hospital, it’s really your opportunity to work with us to mold something that can be really effective.

Lastly, and I want to wrap it up pretty quickly here, but we’ve alluded to, you know, this model, but we’ve also alluded to we were going to do some topics in some advanced areas. And in the advanced areas we try to be very – we try to adhere to our issue of integrating as much as possible yet bringing innovation. So we’re combining the work of VAE and opioid management and delirium together. We are going to have Vanderbilt University as the faculty because they were part of the – they were one – Dr. Eli was one of the principal investigators in the national CDC project that looked at the whole area of delirium and VAE and breathing trials and all of that kind of thing. So we’re going to include that together because frankly much of the same prevention practices that help prevent delirium actually are those that help prevent some of the noninfectious VAE as well.

And the Emergency Room, we really believe that the importance of the Emergency Room having an effective CAUTI protocol around the appropriate insertion of indwelling catheters is important, so that is going to return. And we’re going to take a look at ED CAUTI pilots. In the Operating Room we’re going to take those advanced safety practices. A number of you did some elaborate work at the end of the last HEN on this and we got some extremely positive feedback about our tools, so we’re going to up the ante a little bit and, you know, provide support and education directly to the docs, nurses and anesthesiologists in the OR.

And then glucose management, we can’t say enough about glucose management, both in the issues that still transcend the country and in New York, but also its role in readmissions, its role in surgical site infections, and so we actually are hiring the Society for Hospital Medicine, which has a three-year long collaborative and a wealth of resources that they’re going to work with us to bring to you around blood glucose management.

So that’s obviously not everything, but hopefully it gives you a sense of where our program initiatives are going.

So I want to turn it over to Zeynep because data is always the other issue, and she’s going to go over that whole data piece.

Thanks, Kathy. If we could go to the next slide and get right into it, I know everyone’s – some of you are anxiously awaiting some information on measurement and tracking.

So just a quick overview of the CMS data requirements for this initiative so you are aware of what they’re asking of us. Not a whole lot has changed. On the left-hand side of the column you’ll see we’re still required to submit one process and one outcome measure per clinical topic at a minimum. We are opting to look at some other additional measures A, because we think it will enhance our improvement efforts and our work with you, and B, because we’re not adding any additional measures that will require you to extract them. So we think it will only enhance or provide you with more information.

Just looking at that second bullet, we are required by CMS to pick from a list that CMS has created of a standard set of measures. CMS, as Kathy mentioned at the top of the call, is looking to attribute some of the improvements as seen nationally to these types of efforts and to Partnership for Patients in particular. So it has looked at what other contractors across the country have been collecting over the last three years and created a standard list of measures for all of the clinical topic areas. For the most part, New York State Partnership for Patients has been using most of those measures anyway. We are required to select a majority of those measures and we are already on track and aligned. We’ll be submitting monthly aggregate NYS PFP-level data to CMS on each of those measures. And then, in addition, CMS, as in the past, would like us to identify hospital success stories, so hospitals that have made significant improvements that can be highlighted nationally for their efforts.
In addition, and possibly, you know, somewhat different from the last round, CMS is also looking for hospital-level process and outcome data. They have agreed to allow us to submit this on a de-identified basis, so we will be blinding all of this data. In addition, CMS and the evaluator, which has not yet been identified, will be looking at hospital participants in terms of their engagement, which includes not only participation in these types of statewide activities, but also in terms of data submissions to New York State Partnership for Patients.

They’re also looking at improvement relative to the 20%-40% goals of the program. And then performance relative to national and statewide benchmarks. In the past they had looked at these three areas rolled up into a CMS-defined score. We used to call it the (inaudible) score. All hospitals received reports on that. We’re not sure what this will look like in this round. There’s a new evaluator we think, which will be identified in 2016, so we’ll find out more soon.

And then lastly I mentioned the monthly aggregate cost savings data which we will be calculating and reporting.

Next slide.

Data submissions of New York State Partnership for Patients will look a lot like it has in the past. Most of the measures that we are looking at that we’re going to be feeding back to you will be collected through existing data sources. We want to minimize the burden of data collection for you all. It is one of our most important priorities. So we’re, once again, looking to national registries, state databases, etc. The National Database for Nursing Quality Indicators, NDNQI. Those of you who participate in that and who gave us permission to access your pressure ulcers and falls data in the last round know that it makes it pretty seamless and we can feed back benchmarked reports to you. We highly encourage you to once again grant us permission. We only have limited access to monthly and quarterly data reports through NDNQI and only for those clinical topics, pressure ulcers and falls, that’s all they will give us access to. So for those of you who had not participated in that in the past, we encourage you to do so this time.

It’s a lot like the next registry, which is the National Health Safety Network, NHSN, where you report and we gather infection data. We’ll be grabbing CAUTI, CLABSI, C. difficile, SSI and VAE data out of the NHSN. You can, if you are a regular user of NHSN, at this point in time go in there and you will have an alert directing you to the New York State Partnership for Patients NHSN user group in there. Alissa Kick (sp) who is on the line, has already identified the clinical areas and timeframes for which we will be looking at and grabbing baseline and performance data on. We are looking all the way back to 2010, so if you could confer your rights to us on those as soon as you can, we would really, really appreciate it. We will be coming out to you with more information on both of these very, very soon.

We’re also looking at SPARCS for some of the claims-based measures, particularly readmissions, VTE. We’re going to be focused on a lot of new – well, new for PSP – AHRQ PSIs, which are calculated out of claims measures, claims data, excuse me, and we’ll be feeding that data back to you as well and you don’t have to do a thing.

Lastly I mentioned our partnership with DOH and with IPRO to gather your sepsis data. You’re already submitting sepsis data to IPRO. We know it’s burdensome. We know you’re submitting data to CMS. We don’t want to be yet another data submission point. So we will work with IPRO and get your data directly. You should be hearing from the Department of Health about this very, very soon. We’ll be getting data in aggregate for your hospital, not patient-level data. We don’t want patient-level data and they don’t want to give it to us. So more to come on that, but we’re happy to answer questions as well.

Next slide.

So what are we giving back to you in terms of data resources? A lot of what you saw in the past, I know this was of great value to many of you, and when the Partnership ended, one of the biggest points that was made to us from many, many hospitals that, you know, the benchmarking, the data resources were
really, really helpful and you wished that didn’t end. So we are going to set that back up. We have the New York State Partnership for Patients data portal. You can submit certain measures that we can’t grab from other registries, and that’s less than a third of the measures that we’re collecting, by the way, through the data portal. That data portal, as soon as you enter the data and we have grabbed the data, which used to occur on the 15th of the month, I don’t see why that would change, will be updated on a regular basis and provide you with immediate feedback about your performance relative to the New York State Partnership for Patients average.

Secondly, the dashboard reports. Many of you felt those were very useful, especially in communicating to your leadership about your hospital’s performance relative to various New York State Partnership for Patients benchmarks including facility size and academic status. This gives you little snapshots, small little run charts showing your performance changes over time.

We will give you quarterly PPR, Potentially Preventable Readmissions, reports. Once again, those are those very detailed reports outlining all of your PPRs and walking you through them. Your project manager will work with you on creating your readmissions strategies based on that data and based on those reports.

And then lastly the CMS-developed Hospital Score that I mentioned earlier about engagement improvement and performance.

Next slide. And actually the slide after that.

So that’s it for measurement. That’s all about our approach, at least for now. We will come to you with more information. But what’s next? So we are asking you, once again, to complete and submit the enrollment packet. And if you go to the next slide just for a second, Allison, this is the Enrollment Checklist. You have an email that has a link on our website, and actually if you just go to newyorkstatepartnershipforpatients.org you can find very easily the enrollment page, which includes the Memorandum of Understanding that details all of our responsibilities to you and other requirements of the project is what you can expect from the program in terms of participation and data collection. It also includes a hospital identification and key contact form. That’s attached to the same document. It’s at the end of the MOU. There’s an opportunity on that form to identify the hospital or hospitals for which you are signing the MOU and for which you are responding. Hospital systems or health systems can respond on behalf of multiple hospitals but you have to identify those hospitals explicitly in the form.

And then, in addition on this form, you must include a key contact for each campus, each site, not a health system-level contact, but a hospital-level key contact. Someone who’s senior enough to be able to coordinate and wrangle people up to participate in this program and be responsible for communicating important information to your colleagues, and not necessarily responsible because one person can’t be, for the results, but really act as a key liaison to us.

And then in addition on this form you can identify a system-level contact or contacts. Many of you are from health systems and you want to remain involved and aware of your campuses and how work is going in those areas, so you can identify a key contact at the system level there.

Additionally, you must, in order for us to be able to accept your data, you must execute a Business Associate Agreement with both HANYS and Greater New York. These are also included on the website. This is not for us to have access or anything like that. This is to protect you. This outlines the responsibilities and the stewardship that we are taking on in handling your data, so we really encourage you to make sure you have this in place as soon as possible.

And then lastly, submit the full enrollment package to NYSPFP as soon as possible. The sooner we have it the better. The deadline is October 30th, however.

So if we could just go back one slide. Thank you.
So secondly, we’ll be scheduling a conference call or meeting with you as soon as possible with your NYSPFP-designated project manager. They will be in touch as soon as you return your enrollment materials, especially that contact form. In fact, if you want to send that key contact form to us as soon as possible, if there are, you know, if there’s a longer process for the MOU and the (inaudible)AA, you can send your key contact form and we can start the conversation with your key contact as soon as we get it.

And then thirdly, I mentioned completing the process for granting us permission to access your NDNQI and NHSN data. You can go ahead and do that in NHSN already. We are awaiting instructions from NDNQI, and we’ll be back in touch with you really, really soon.

And then lastly, look out for NYSPFP announcements in your Inbox. Sometimes because we’re sending to large groups, these could end up in your junk mail or spam folder. If you could check your spam folder, you should have received something this morning reminding you of this conference call. If you did and it went into your junk mail or your spam, I would ask that you put us on your Safe Sender list, and that way you’ll be sure to get all up-to-date information on an ongoing basis.

So that’s it. We have – we’re just three minutes past where we wanted to be, and I’d like to open it up for questions. It looks like we have some coming in through the Chat already.

(Inaudible.)

Zeynep, do you want to take the first question?

Sure. So Laurie is going to read it.

There was a question on the deadline for submitting the enrollment packet, which Zeynep mentioned as October 30th ideally. And we’re more than willing and happy to help you work through that packet if it’s the first time and you haven’t done it before.

There is a question on the delirium measures. What are the delirium measures? Zeynep, is that you?

(Inaudible) Nancy.

Okay. On the delirium measures, what we’re actually doing is, if you remember we mentioned that we’re incorporating as part of this critical care special project around VAE and delirium, so there will be an overall delirium rate in terms of the outcome measure. But then we’re looking at the very traditional and extremely important three assessments, the assessment for pain, the assessment for agitation, the assessment for delirium to be done. We’re not – we’re going to do it on a monthly prevalence study approach where you only have to request data once a month, so we really were very conscious of not making this burdensome. But it’s very standard. So delirium rate and the PAD assessment tool, adherence to them at least once a day, and data would be collected through a month prevalence approach.

Yep. And more to come – much, much more to come – on those measures, right Nancy?

Oh, absolutely.

Absolutely.

Okay. So the next question is, and this came from a couple of participants, are hospitals required to participate in all focus areas? And the simple answer is you’re not required to participate in anything since this is a voluntary program. But I know that’s a loaded answer. So the answer I think you’re looking for is what is CMS’s expectation. And with respect to that, CMS does expect hospitals to address all areas. And it’s really emphasizing this harm across the board approach, so it’s really about looking at things systemically. But in terms of engagement, since we will be submitting the degree to which each hospital is
engaged in the Partnership for Patients, that includes data submission and participation in programming. And data submission in particular will be an indicator to CMS as to a hospital’s level of engagement in any single topic area.

So short answer is no, you’re not required to, but longer answer is CMS is looking at the levels of participation for each hospital, and that is the one area in which it is asking us to identify by hospital, and this is the case for all Hospital Engagement Networks across the country. We’ve mentioned the attributions of improvement to Partnership for Patients efforts over all. And what they’re going to be doing, or what they’re going to ask their evaluator to do, is actually compare the performance in each of these areas of hospitals that participated in Partnership for Patients and those that did not. So they’re very much looking at everyone’s engagement and participation, but, obviously, it’s a voluntary program.

The next question that’s coming, I’ll take that because it’s on critical access hospitals, but I want to add to my answer on delirium. We’re also only asking for that data on one target unit. You’re certainly encouraged to spread it to other critical care areas, but we’re really only focused on one.

There’s a question about will the work on the critical access remain separate or aligned, and I thank you for asking that question. We have a separate New York State Partnership for Patients Rural Critical Access Pod. It functions very differently than the rest of the hospitals. We will continue with that specialized approach. Those hospitals sort of – they get their choice. They can continue to participate with the statewide activities that we’re doing throughout the whole program, and they have also activities and sessions specifically to meet their unique needs. So we’re going to do it in the same way we did in HEN 1.

In terms of when will project managers be assigned, when we got all our enrollment in. So send your enrollment as soon as possible, by October 30th. When we know all the hospitals that are on board, we will be able to then, you know, do a good job of assigning project managers. We do have 13 people we can put out in the field with a variety of expertise this time, and you have heard from the beginning that we really, really want to focus on frontline support, so I think the whole project manager, and perhaps even backup project managers, is going to be really important to us as well.

I don’t see other questions. Anyone have their hand raised, Allison?

No, everything is in and that’s to All Panelists. One more just came in. Where can I find a complete list of measures?

Okay. So nowhere just yet. We are working on finalizing the definitions of those measures. We have the measure list, which I suppose we can provide almost immediately, but we wanted to be able to give you a detailed definition for each measure, and that is coming soon. We hope to have it in the next week to ten days.

There’s a question about hospital liaison forms and only one contact person. We’re going to do that a little bit differently. We had a lot of confusion in HEN 1 around sending, you know, private messages to the key liaison person and all of a sudden the key liaison person was multiple people. And so to try to avoid some of those complications, we are actually asking for just one liaison person at the corporate level and one at the hospital level. However, there’s provisions for what we’re calling Champion, and those are all the other people that should get high-level communications in addition to the liaison person. And we’ll do that one-on-one with you once we get started.

Right. So the next question is about whether – so the participant says, VTE seems to be challenging to make gains in New York State. Will there be a concentrated effort from PSP to address this issue, for example dedicated VTE webinars and conferences? And we hear you on that, and I don’t think that’s focused just in New York State. It seems to be a national challenge, and there’s been a lot of conversation about whether it’s even something that the hospitals can impact. So at this point in some cases whether the measures actually accurately reflect what’s happening. So we are, of course, going to
be focused on VTE. Some of the challenges seem to be nuanced at each of the hospitals. We did a lot of VTE programming in the past three years, and as Nancy emphasized, we heard you loud and clear when you said please minimize the amount of statewide webinars. So VTE will be a focused effort. We have some very thoughtful strategic planning tools and gap analysis tools which your project manager will reach out to you to explain and will address VTE on a more customized basis.

That said, we are all about pivoting when we need to. So if we think – if we hear from you all that there is a need to address this in a statewide manner through education and webinars, we can absolutely do that. So we’re going to take it as it comes.

Perfect answer. Is there any other questions?

Yes, it looks like – and I’ll take this, too, Nancy, I’ll read it to you. It appears as though medication reconciliation is not included as it was in the last round. Can you address that?

Well, actually I think it is, and I’m going to take off on (inaudible)’s perfect comment about the fact that we’re going to pivot if we need to. Medication reconciliation, when the data comes out, you’ll see is still a process measure for readmission. And it’s still a process measure involved in ADE. So what we’re going to do within those areas is take a look at and get some feedback from you all, particularly because we’re going to have this big focus effort around blood glucose to see where the needs are. And you will be hearing from us in terms of education or programming in that area. So we haven’t forgot about it. It’s just we really need to be a little bit more centered with where it is targeted.

Okay. And I see one last question. How will we be able to access this list – I’m assuming you’re asking about the measures list. We should have mentioned, and I can’t believe we neglected to, the nyspfp.org website is your answer to where all these resources are and will be. On a rolling basis we update that website frequently. You will see in the next day or two that website updated with a recording of this webinar for your colleagues who may have missed it, and the slides. You will also see that measures list in the data section. It will be called Measurement Grid. And then there’s a companion document to that called Methodology document, Measures Methodology document, which will give you much more detail on each and every one of those measures. So keep an eye out for that.

We will be sending you email every time we post anything major on that website, like the Measurement Grid, so also keep an eye out in your Inbox. And as I said, put us on your Safe Sender list and you’ll be sure to get those updates.

Okay.

Actually, Nancy, I’m so sorry. In addition to the website, we might want to mention the newsletters.

You know, absolutely. We’re going to continue to put out our newsletter. You were very positive about that last time. We will continue to keep them brief and succinct. At this point we’re going to consider going to two times a month versus weekly, but as we sort of get the feedback and hear what’s going on with all of you over the next month or so, we could modify that. But the newsletters will be back.

Great. I don’t see any questions, and we are right at the top of the hour. Thank you, everybody. Thank you so much for dialing in, and we really look forward to hearing from you, and receiving your enrollment package. If you have any questions, please feel free to reach out to any one of those four people, or anyone else you know at HANYS or Greater New York that you know works on this initiative. We’re all prepared to hear from you, and look forward to speaking with you. Thank you so much.

Thank you.