OHA HIIN Partnership for Patients
Letter of Commitment

To:

Re: Request to Participate in the Ohio Hospital Association Hospital Improvement Innovation Network (HIIN) Contract

Date: September 28, 2016

We have reviewed the information for participation in the Ohio Hospital Association (OHA) Hospital Improvement Innovation Network (HIIN). We understand the work is being coordinated by OHA's Institute for Health Innovation (IHI) and the Ohio Patient Safety Institute (OPSI).

This letter of commitment indicates hospital senior leadership commitment to the AIMS of the Partnership for Patients with emphasis on the reduction of three key areas: All-Cause 30-Day Readmissions, Clostridium difficile, and promote Antibiotic Stewardship. Our hospital commits to work with OHA, OPSI, and OHA HIIN to reduce all-cause 30-day readmissions statewide by 12% and to reduce CDI by at least 20% based on the 2014 baseline.

The signature at the end of this letter indicates our commitment to participate in HIIN of the Partnership for Patients initiative and to complete the program expectations. We understand this commitment includes: baseline and monthly submission of data, meeting with the assigned regional coordinator, monthly conference calls, and ongoing participation in the performance improvement project.

We understand that this type of work is not without effort. Based on the experience of OHA/OPSI in leading similar collaborative projects, we have outlined the health care facility's commitments necessary to maximize the potential for success:

Participating Health Care Facility Commitments:

1. We will work with OHA to assess our organization's current improvement projects and areas of need for improvement. We will implement OHA's recommendations for our organization's participation in this project whether that will be to sustain our current improvements or to implement new initiatives.

2. We will form a multi-disciplinary team which will include:
    - Senior health care facility executive champion(s)
    - Site project team leader
    - Physician champion(s)/epidemiologist(s)
    - Quality/process improvement specialists

- And others as appropriate such as:
  - Nursing manager/director/champion(s)
  - Bedside nurses and pertinent clinical disciplines
  - Data collector/submitter (if different than someone listed here)
  - Infection control practitioner(s)
  - Pharmacy
  - Laboratory

3. Recognizing that in addition to meeting the base 20/12 reduction goals, HIIN is continuing to place additional emphasis on the following:

- Adverse drug events (ADE) to include opioid safety, anticoagulation safety, and glycemic management
- Catheter-associated urinary tract infections (CAUTI) to all hospital settings, including avoiding placement of catheters in the ER and in the hospital
- Central line-associated bloodstream infections (CLABSI) to all hospital settings
- Clostridium difficile (C. diff) infection, including Antibiotic Stewardship
- Injury from falls and immobility
- Sepsis and septic shock
- SSI to include at a minimum, colon, abdominal hysterectomy, total hip replacements and total knee replacements
- Venous thromboembolism (VTE), at a minimum to all surgical settings
- Ventilator-associated events (VAE) to include Ventilator-associated conditions (VAC), infection-related ventilator-association complications (IVAC) and ventilator-associated pneumonia (VAP)
- Readmissions

4. In addition to the required base measures outlined above, our facility will participate in the selected initiative(s) below (**select at least one**):

- ☐ Multi-drug Resistant Organisms (e.g. MRSA, VRE, CRE, etc.)
- ☐ Hospital culture of safety that fully integrates patient safety with worker safety
- ☐ Iatrogenic delirium
- ☐ Developing a metric to measure and report all-cause harm within the HIIN Network

5. We will submit the required outcome and process measures on a monthly and quarterly basis to the OHA, allowing enough time to provide aggregate data to CMS by the assigned due date. We acknowledge that timely data submission is of utmost importance to achieving expectations. This data in aggregate format will be shared among project participants and the leadership team partners for benchmarking purposes to promote improvement. We understand that submitted data will be held in confidence and will be kept in accordance with HIPAA policies. OHA is required to submit the process and outcomes measures at a hospital level. OHA HIIN will submit aggregate hospital level data to CMS either by hospital name or assigned number based on the decision of the majority of participating hospitals.

For HIIN we will:

- Develop an action plan based on a completed gap analysis
- Implement harm reduction strategies to meet or exceed HIIN improvement goals
- Have at least one participant on monthly content and coaching calls, including appropriate individuals in the target audience
- Incorporate patient centered, person and family engagement and safe care practices into all methodologies
- Consider health disparity and health literacy in the development of patient education materials, communications, and care planning
- Incorporate antibiotic stewardship into improvement plan
- Host the regional coordinator onsite on a quarterly basis
- Submit monthly data collection by the established due date
- Meet regularly with team to develop strategies for improvement and reporting process
- Share internal data with leadership and staff so they can continually work on improvement plan
- Conduct educational programming for staff to meet the project goals as appropriate
- Identify any problems with project implementation and alert the regional coordinator as soon as possible
- Collaboration with other hospitals participating in the OHA HIIN
- Attend internal team meetings
- Share effective practices with regional coordinators

As an organization, we understand that OHA will provide us the following to assist in implementation of the HIIN agreement:

- Outcomes data using existing data sources
- OHA will obtain data from NHSN on behalf of our organization
- A web-based data entry site to enable timely data collection and submission
- Free access to Wayfinder and associated data reports for the duration of HIIN
- Hand Hygiene Process Observers to collect up to 150 hand hygiene observations monthly from our organization at no additional cost to us
- Educational programming and resources related to the HIIN topics
- Regional Coordinators to serve as a reference and support to our organization
- Engagement awards based on our level of engagement and level of attainment of benchmarks at the end of the contract (see Attachment 1)

Through participation in the Hospital Improvement Innovation Network Contract, we will provide OHA with the following:

- Baseline data and metrics
- Monthly process and outcome measure data either by granting access to NHSN or enter data onto the OHA data entry site
- Quarterly process and outcome measure data through existing administrative data set
- Participation by at least one member of our organization in monthly coaching calls, webinars, conferences, etc.

- Participation as a mentor facility, as requested and able, for an area of identified strength

CEO/Senior Executive Champion

Name of facility

Address of Facility

Date

Point of Contact (Project Team Leader)

Point of Contact Email

Point of Contact Phone Number

Return this signed commitment letter to:
Rosalie Weakland
(Rosalie.weakland@ohiohospitals.org or
phone 614.221.7614, ext. 132)
Ohio Hospital Association
155 East Broad St, Suite 301
Columbus, Ohio 43215-3620
OR
FAX TO: 614-358-2741
Attn: Rosalie Weakland

Attachment 1:

Engagement Award

Participation and engagement are requisite for achieving the intended metrics of the hospital engagement network. In recognition of the diversity that exists within Ohio hospitals with respect to engagement, the following strategy will be used to ensure participation and engagement through spreading of effective practices and mentorship. Four categories of engagement will be monitored monthly by regional coordinators utilizing a scorecard format, including:

- orphan hospital rapid implementation
- mentorship
- effective practices facilitation
- goal attainment

At the conclusion of the award cycle, it will be possible for participating hospitals to receive a financial award based upon their status in each of the available categories. The following table outlines the categories and their related criteria and award opportunity.

CATEGORY	CRITERIA	POTENTIAL AWARD
Orphan Hospital Rapid Implementation	*Only hospitals who have not previously participated in a hospital engagement network will be eligible for this category. Initially, the hospital must submit baseline outcome data for the period of Q1, 2014 to present. The hospital must initiate monthly reporting processes. A multidisciplinary team must be established to address all hospital acquired conditions. The hospital must select a minimum of one additional topic. Routine meetings with a regional coordinator are required. A detailed communication plan in which results are reported throughout the hospital will be requisite.	$4,000
Mentorship	*Only hospitals who demonstrate a high level of success in a minimum of one measure, as evidenced by sustained high performance at HIIN-wide benchmark or a 20%/12% reduction from baseline, will be eligible for this category. The hospital must be willing to interact transparently with other hospitals regarding their strategies for success.	$2,000

CATEGORY	CRITERIA	POTENTIAL AWARD
	The hospital must demonstrate the dissemination of tools, policies, forms, protocols, or internally developed educational materials to a minimum of one other hospital. The hospital must demonstrate the active facilitation of progress from baseline performance of a minimum of one other hospital. *Note: this pertains to hospital level mentorship and is not automatic award to all hospitals within a health system	
Effective Practice Facilitation	*All hospitals are eligible for this category. The hospital must provide a minimum of one presentation of effective practice at the regional, state, or national level using principles of adult learning via live, remote, self-directed, or poster presentation. The hospital must actively participate in a minimum of 50% of coaching calls related to the effective practice area. The hospital must demonstrate the dissemination of tools, policies, forms, protocols, or internally developed educational materials in this presentation, utilize current references, and cite clinical evidence. *Note: this pertains to hospital level mentorship and is not automatic award to all hospitals within a health system	$2,000
Goal Attainment	*All hospitals are eligible for this category but also meet the criteria for mentorship or effective practice facilitator. The hospital must: For a minimum of seven hospital acquired conditions a) Attain sustained high performance at HIIN-wide benchmark -OR- b) Attain 20%/12% reduction from baseline The hospital must demonstrate a reduction in a minimum of one of the additional topics: -MDRO	$5,000

CATEGORY	CRITERIA	POTENTIAL AWARD
	-Integration of worker/patient -safety -Iatrogenic delirium - Developing a metric to measure and report on all-cause harm The hospital must demonstrate consistent implementation of a minimum of FOUR of the following person and family engagement strategies: 1) Prior to admission, hospital staff provides and discusses a **planning check list** with every patient that has a scheduled admission – allowing for questions or comments from the patient or family - a planning check list that is similar to CMS's Discharge Planning Checklist 2) Hospital **conduct shift change huddles and do bedside reporting** with patients and family members in all feasible cases. 3) Hospital has a **person or functional area**, who may also operate within other roles in the hospital, that is dedicated and proactively responsible for Patient and Family Engagement and systematically evaluates Patient and Family Engagement activities (e.g., open chart policy, PFE trainings, establishment and dissemination of PFE goals). 4) Hospital has an **active Person and Family Engagement Committee** OR at least one former patient that serves on a patient safety or quality improvement committee or team 5) Hospital has at least one or more patient(s) who serve on a **governing or leadership board** and serves as a patient representative	

OHA PfP HIIN QUALITY METRICS AND BENCHMARKS

Below are listed the CMS identified benchmarks for the core preventable harm focus areas. If a hospital has meet the benchmark or reduced a given preventable harm focus area by 20% from baseline, it will be optional for them to attend educational programming and submission of the associated process measure(s) for that given preventable harm focus area but will still be required to submit the outcome measure for the area.

Preventable Harm Focus Area	Measure	Benchmark
C. difficile	National Healthcare Safety Network (NHSN) Outcome Measure Standardized Infection Ratio (SIR) Rate – CDI/10,000 patient days	CDI SIR – 0.745 CDI Rate – 4.40
Sepsis	Sepsis mortality	Not defined
Catheter-Associated Urinary Tract Infection (CAUTI)	4. National Healthcare Safety Network (NHSN) CAUTI Outcome Measure (NQF 0138) Standardized Infection Ratio (SIR) • Intensive Care Unit (ICU) Units, excluding Neonatal Intensive Care Unit (NICU) • ICU + Other units 5. Catheter utilization ratio (catheter days per 10,000 patient days)	ICU CAUTI – 0.6 House wide CAUTI – 0.48 SIR – 0.63 Catheter Utilization ratio – not defined
Central Line-Associated Blood Stream Infection (CLABSI)	6. NHSN CLABSI Outcome Measure (NQF 0139) (SIR) • ICU Units, including NICU • ICU + Other units 7. CLABSI utilization ratio (central line days per 10,000 patient days)	ICU CLABSI – 0.40 House wide CLABSI – 0.18 SIR – 0. 32 Catheter Utilization ratio – not defined
Falls	8. Falls with injury (NQF 0202) (NDNQI) • All acute care units	Falls – 0.5
Pressure Ulcers (PrUl)	9. PrU rate, Stages 3+ (Agency for Healthcare Research & Quality [AHRQ] PSI-03) 10. PrU prevalence (hospital-acquired) (NQF 0201) (Stage 2+) (NDNQI)	PSI-3 (all payer) – 0.246 PSI-3 (Medicare) – 0.328 PrU Stage 2+ - 1.487
Venous	11. Post-Operative pulmonary embolism	PSI 12 (all payer) – 0.556

Thromboembolism (VTE)	(PE) or deep vein thrombosis (DVT) rate (AHRQ PSI-12)	PSI 12 (Medicare) – 0.369
SSI	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific SSI Outcome Measure (NQF 0753) (SIR) 12. Colon surgeries 13. Abdominal hysterectomy 14. Total hip replacements 15. Total knee replacements *Note: SSI national measurement considers all procedures; therefore, the HIIN interventions and measurement shall cover multiple classes of surgeries*	SSI SIR – Colon – 0.59 SSI SIR – Abd. Hyst – 0.6 SSI – TH SIR – 0.605 SSI – TK SIR – 0.414
Ventilator-Associated Event (VAE)	16. Ventilator-Associated Condition [VAC] 17. Infection-Related Ventilator-Associated Complication (IVAC)	VAC – 2.845 IVAC – not defined VAP – 0.66 VAP SIR – 0.6
ADE – INR	# INR readings >5/# of INR readings	2% of INR readings >5
ADE – Glycemic	# BG readings <50/# of BG readings	BG readings – 3%
C. Difficile	NHSN CDI rate (CDI/10,000 pt. days)	CDI - 4.4
Readmissions	30 day Medicare FFS All- Cause readmission (per 100 discharges) 30-day All Payer All- Cause readmission (per 100 discharges)	Medicare readmission – ≤15.26 All Payer readmission – 12% reduction from HIIN Baseline (8.37)