Good afternoon everyone. We want to thank you for joining us today for our third NoCVA preventing avoidable readmissions collaborative pre-work webinar. Today's webinar will focus on collaborative measurement. With us today we have Erica Preston-Roedder, Director of Measurement at the quality center. Also with us we have Laura Maynard, Director of Collaborative Learning. Before we get started today, I want to review some logistics. This webinar is being recorded and will be posted to the NoCVA Preventing Avoidable Readmissions webpage shortly after the conclusion of the session. Currently, all lines are muted and listen only mode. As always, we encourage you to participate in and ask questions. We ask that you do so by using the chat, and selecting chat all participants. If you are calling on the phone, you may ask your question live by clicking on the hand icon on the right-hand side of your control panel. We will unmute your line and you can ask your question live. Please remember to announce yourself and the hospital that you represent before speaking. At the conclusion of the webinar, there's a short evaluation and we ask that you take time to complete that for us. There are four questions and we use this information to help us in planning future webinars and we do appreciate all your feedback.

Before I turn things over to Laura, we'd like to test the chat feature. If you could type in your hospital name and the number of people joining you on the webinar and please be sure to chat to all participants. Laura, while they do that, I will turn things over to you.

Thank you, James. Advance one slide. We'll talk about the agenda for today's webinar. While we are doing that, do click on all participants and chat in which hospital you represent and how many people I with you today, that we have a feel for that and you have a feel for how to operate the chat feature.

The agenda today, we will give a little bit of context, just a reminder of some of the overview of the collaborative, it else. Then, we will talk predominantly about the measurement for this collaborative. The metrics, what are they and why? The details around the measures. How to collect the measures and enter those measures. Any resources that we have for you about how to do that. Erica will present a lot on our data manual that is coming up in the types of reports we will be giving you. Then, we want to talk about how to make the data work for you so that is meaningful and driving your improvement. We will show you a sample of the data monitoring plan and how you might use that. Also, talk about the next apps for the collaborative, in terms of making sure everyone is caught up on the pre-work and ready for the in person session. Our goal, overall, is that you understand enough about the measures that we ask for. That you can identify the work plan and be able to write down a list, so that as we go through the webinar, of you have a question, feel free to speak up and make notes for yourself in regard to what you need to be looking for. How to put this in place with your measurement plan. What you need to know and ask. How can I find out what I need, in order to be able to meet these deliverables and use these measures.

General context for the collaborative, we want to focus back to the idea that our mission in coming together and working on this is to improve the transitions in care and thereby
reduce the avoidable hospital readmissions, the preventable hospital readmissions. We talk a lot about reducing readmissions. We know there are reasons to do that. I want us to remember that quality patient care is at the core of that. The real reason we want to reduce avoidable hospital readmissions is because that's better for our patients. It's better quality care. They don't want to be readmitted to the hospital. If there transition has done well and a patient centered way and truly an effective way, there are going to have the benefit of that good quality care in addition to the benefit of not having to bounce back to the hospital.

The primary methods for doing that are listed out here. I'm not going into a lot of detail. We've shown this repeatedly on the pre-work. But, you need to pick a pilot unit, have your team together, do an assessment of five recent readmissions using the IHI diagnostic tool. You need to serve your discharge process and develop a process map of that. Figure out your risk assessment for risk of readmission and then follow-up appointments and follow-up calls or visits with those folks assessed at high risk of readmission. Part of what we talk about is detail, today. The other methods are to test and track some improvements in these four key areas that have been identified by IHI as being key to enhancing care transition. Enhanced assessment of the patient's post hospital needs, enhanced patient learning, ensuring that the post hospital care follow-up happens and it's appropriate, and providing real time handover communication. Those are the four key areas we want you to work on, particularly internal to the hospital. At the same time, we want you to look at your community cross continuum team and the work that needs to be done within the community for those folks who receive your patients when their discharge from the hospital. How you can make improvements in those relationships and make improvements and transitions and implement and spread the improvements. Is to provide a little bit of context about the overall approach, the mission and methodology. Out, I'm going to turn it over to Erica to bring us to the specifics of how we might get that to happen.

Thanks, Laura. My job -- when I was talking to the team about what would be a good way to do this, they asked why we should talk about collecting these measures at all and give us some context. What's the story about how we collect these measures and why we picked these measures? I want to start with that big picture before we get into details, the numerator, the denominator of when you look at the data, etcetera.

Laura was talking about the collaborative approach and there are a lot of different moving projects. You can work internal, external with meter to relationships. The core of what you are doing is trying to improve transitions in care with the hope of reducing readmissions. That's the mission of the overall collaborative. In particular, the thought with this collaborative, is that you improve transitions in care for your high risk patients and it's going to reduce your readmissions. What I've done here, for -- I've visually mapped out what I see as the core of the work you are giving. We want to of pain fewer readmissions. How are we going to do that? Provide an enhanced follow-up plans for -- plan for high-risk patients. In particular, we are going to ensure that the high-risk patients receive a follow-up visit with their provider within seven days and that they get a follow-up phone call or home visit within three days, from us. Those are the two ways, core ways we enhanced the follow-up of high-risk patients. Before I do any of that, I should be able to identify the high-risk patients. That's where, step-by-step, how you get fewer readmissions. Here's the key work we are doing. Along with that, of course, you need to
improve the interim processes. Deep in the community relationships. That will help you do a better job of identifying high-risk patients, enhancing their follow-up care. Also, it will help you and a lot of other ways, as well. When you move the needle in readmission rates, some of it will be to enhance follow-up care for high-risk patients. Undoubtedly, as you did, you will find other opportunities to pursue, as well. We want you to surface those through your work and working on community relationships.

Hopefully, this representation of the key work is around transitions of care for high-risk patients. This picture will help bring these together and ground us to get to all these details, when you keep coming back to this picture and say, why are we doing this? What are we trying to accomplish? Looking at that key work.

Given the picture of what we are trying to accomplish, the process measures fallout fairly naturally from that. We are going to look at the process measures and the outcome measures. Let go back for a second.

If this is what we are trying to do, clearly, outcome measures you will look at is whether or not you have fewer readmissions. As I talked, you can see that we asked you to look both at the hospital level, whether you have fewer readmissions and also at your pilot units for populations. Whether you have fewer readmissions. Out of line measurement is backed actually move the needle on readmissions? Also, is there an impact across my whole hospital? That is the bottom line outcome measure. In addition, we also will look at process measures, because it takes time to see outcome measures move. Sometimes really want to have an evidence of progress on a process measure, on your process measure run chart. While you wait to see the outcome and packed. Also, as he tried to figure out whether the changes you’re making on the ground are working, you want to measure the processes, look at the process measures you can see if they are successful in implementing provider follow-up visits within seven days or phone calls within three days.

We want to look at those processes, not just the outcome side. The process measures are going to see will be focused on those two boxes on the left. One is looking at measuring processes around the follow-up visit with the provider within seven days. You actually get those scheduled and get those phone calls or home visits made. Also, are you identifying the high-risk patients before discharge?

That is on this page of the presentation break the process measure we use for this is the percent of patients given assessment for high-risk readmissions. Step one of the process is identifying those patients. Want to be able to identify 95% of your patients. That means given assessment to 95 of your page -- 95% of your patients to see if they are high risk or not.

The next is looking at whether you actually get those those follow-up visits scheduled within seven days with the high-risk patients. Process measure goal is hitting 95%. 95% of the patients get their follow-up visit scheduled. All of this is on your pilot or population. You are not doing it hospital wide, yet here starting on the pilot. The third is high risk of patients who have a follow-up phone call within three days. You can also be a home
visit. The goal is 95%. The last one is a corollary, the present of high-risk patients who cannot be reached. And you try to make these phone calls, there may be patients who you -- you go through all the processes and your end and you can't reach the patients. You need to balance that and keep track of that to see where you have implementation challenges. That is also process measure.

I will talk about more of each of these.

The next 20 slides or so are all -- I'm going to talk about each measure one at a time. If you have questions while I talk about them, feel free to chat them in. I'm happy to answer them along the way. Right at the outset, I should say this is not the only resource you will have for understanding the measures. Have a data manual, which will be posted online. It will be posted early next week and has all of this written out, as well. Of course, this is the first in-depth discussion of these. I anticipate we will talk about these measures, certainly, on June 18. You can now is follow-up with myself or other staff here or your coach, as well. I will go through each of these at a reasonable pace. Stop me if you have questions. We will try to get a handle on the different measures.

On the outcomes side, we will measure readmissions. We will measure two different readmission rates. One of the hospital level rate. Rats most important thing for you to know, right now, is that you are not submitting this. We pull it off from the back end. Don't have to do anything around this except monitor the feedback you get, track it, understand it. Very brief definition, this is an all payer all cause readmission rate. Every patient, every reason, every time. Not the same as the Medicare readmission rate. There is a technical difference. We talk more about those in a later webinar, or I can answer questions now. It's not risk-adjusted. People ask that. I've been asked weather observation patients are included. They are not included. It only looks at inpatient. The other thing you should know, the data for this readmit rate trails pretty far, about six months after the close of the quarter. It can pretty -- you could be pretty far in this collaborative before you see any claims based impact from the hospital wide measures that we track.

That is what I think you need to know, basically, about the overall hospital wide rate.

I don't see any questions in chat. If you do have them, feel free to chat those in.

I'm going to move on to the other outcome measure. This time, we are looking at the unit or population level for the readmission rate. If each of you works with the specific unit or population, it might be the heart failure population, the diabetes population. It might be units 3 B. Each has a specific, clinical or geographical focus within your hospital. What we ask you to do, is to work with the existing hospital resources you have to track and outcome measure for that patient population. I go back almost to quality improvement basics with your PDSA cycles and how you can do it true quality of the project of any sort without seeing a few are making a difference. This is really about being able to call out or report some sort of the readmission rate for the population that you are working most intensely with. So that you can see if those patients really are readmitting less often.
Get beyond anecdote. A benefit to you is to track the unit or population level, from having done in the past. It's very frustrating when a team does excellent work with a specific unit or population, but they don't do the impact hospital wide, yet, because they haven't moved hospital wide, yet. You want to have a story to tell and it's nice to take it to senior leaders in a run chart or something that we have really made a difference in quantified it for the population. This is good stuff. Let us do more of this elsewhere. Being able to track the readmit rate for your unit or population will help you in so many ways. It will help you know whether what you are doing on the ground is actually making an impact. It can change course if you need and also gives users or he to tell for your senior leaders to advocate for more resources or to continue this work.

A couple of things about this. I anticipate that each hospital will define its readmission measures slightly differently. All of you have different data system, different data resources. There are a lot of technical details about readmission rates, such as whether or not if someone comes ask five times in one week you have five readmissions or count it as one. If that person is readmitted once within a 30 day period. There are complexities around if they readmit to a different hospital. Some of you have system level data and can track it for your systems. Some of you won't. We know that each of you will be tracking it slightly differently. I do not think the readmission rates will be comparable between hospitals, for that reason.

For instance, I hospital who catches readmissions that other hospitals in the system will probably have a higher readmit rate overall than a hospital who is not able to track the readmissions of other hospitals. Am not anticipating using this to compare hospitals to each other, but clearly, just for each of you, to compare to your own baseline and for us to look at something like how you make progress. Are your numbers going in the wrong direction? This is one of the measures that if you track yourself well and get your baseline, but don't really compare against other hospitals.

A couple other big considerations. Actually, smaller considerations. I encourage you to include readmit.

To any part of the hospital, not just your unit, if that's possible. Some hospitals might end up doing this in a data system or on paper. You've got to do what's feasible for your hospital. I think this is an important enough measure that you should work to stretch what is feasible. I know that different hospitals have limitations.

Ideally, you include readmit.

To other hospitals, such as those in your system. If you have that available. I would talk to your hospital resources about same-day readmit. Ask a couple of questions. Sometimes transfers get miscoded as same-day readmit. I would also, ideally, suggest including observation patients, if that patient is housed on your unit even for observation, that's an opportunity to keep that patient from subsequent admissions and improve their care transition, etcetera. Ideally, I would suggest including those observation patients.
Although, again, you have to do what's feasible. I've talked to a couple of hospitals and I know what's feasible really varies by facility.

A note on time frames. I anticipate that most hospitals won't have good historical data on units or populations. We have good historical data on your hospital rates, but it may be that you don't have years and years worth of data about your specific unit or population. You may have no data right now I just starting to track with this model. If you have historical data, you have the option of an trading -- of entering that data. Does allow for better trained thing. It's an option, but I anticipate most of you will not have that back data. I went into the details of fair amount. Let me zero back out and give you the big picture. The big picture on readmit rates for populations, it's very important. User available hospital resources. It's okay if your internal hospital readmit report doesn't perfectly capture your specific unit of population. It might be a few heart failure patients and the support you can pull doesn't quite capture all the heart failure patients that you consider yourself responsible for. That's okay. Don't let it be the enemy, in this case. What you need is a directional indicator that tells you whether or not and general you are making a difference with your work. A few have that feedback and say we've moved our numbers in the last quarter, let's keep doing this. Or, we haven't moved our numbers and we need to go back and assess why. This is a measure you build for your performance improvement work, not for a clinical study. Not for joint commission accreditation. This is about aching this measure work for you in your work.

Any questions on that? The only sad I can think to add, for those of you that have been a part of the collaborative in the past year and maybe you've had two years, we are encouraging you not to stick with the same units through all those years. If you've been fairly successful in a unit or population, for those returning hospitals, we want you to pick another one or two. Start thinking about how you will spread this from the initial pilot unit, read what you've learned. Track what you've learned and apply this process of tracking the readmission rate for that unit for the new unit that you are picking to work on this year.

Thanks, Laura.

Okay. Talked about how we measure [Indiscernible] fewer readmissions. Will measure at the hospital level and look for your unit of population. A, you want to talk about process measures. We talk about each of the process measures, intern. Some of these are the same as last year. Some are slightly different ear for the first process measure, it's a percent of patients given an assessment for high risk. That definition is pretty simple. The number of patients discharged from the pilot unit or population would have been given that assessment. The denominator is all the patients discharged from your pilot unit or population.

Your goal, here, is to assess 95% of your patients.

Samplings permitted, although discouraged for this measure, if you are sampling, would
like to see you report a 25 patients per month or 10% of patients on unit or population, whichever is greater. We do want used to assess your observation patients, as well. If they are seen on your unit or population, that's an opportunity to assess them for high risk and see if they need to follow-up care so they don't down.

To the hospital two weeks later. Three weeks later, next month.

Moving on, the process measures, the next is% of high risk patients that a follow-up visit is scheduled within seven days. Try to enhance the care transitions and enhance the follow-up care that patients need. The numerator is the number of patients in the pilot unit or population who are at high risk and are scheduled for a follow-up visit within seven days of discharge. The denominator is simply the number of patients who are at high risk and the pilot unit or population.

Notice that for all the subsequent process measures we are looking at, how this performance looks like for those patients who are high risk without being asked to schedule follow-up visits for all patients who are seen under pilot unit or population. Certainly, do so if you have the resources in place work we are zeroing in on making sure those patients most needed are getting that enhance level of care.

A couple of brief details on this one, as well. Woman to say a follow-up visit within seven days, we mean seven calendar days. Also, I would at that patients who die in the hospital can be excluded from this measure. Hospice, transfer and AMA patients should be included if they have been assessed at high risk.

If I hospice patient is high risk for readmission or transfer patient or AMA patient is assessed at high risk for readmission, you may want to include them in the denominator and also in the numerator, of appropriate.

A little bit more on that. Last year, we got questions about what to do if the next side of care is responsible for making the follow-up appointment. It might be the case for transfer patient or a hospice patient. Here's the guidance we offer you. This is a little bit messy in the real world, at this point. The goal is to make the measure useful for your work, to help you identify actual gaps in care that you can address and make better. Here is the guidance we give in that case.

If another site of care is responsible for making the follow-up appointment, you can count the patient is having a follow-up visit scheduled if the following criteria holds. You told the next side of care that the patient is of high risk for being readmitted. To have that conversation with the next side of care so they know there is an enhanced need for that patient to get that follow-up visit.

Not only do you convey they are at high risk for readmitting, but the patient needs to have the follow-up visit scheduled within seven days of being discharged to the next side of care. Final, they reasonably the next light of care will act on the recommendation. If you tell them in a note that goes along with the patient's record, that's not sufficient are
you having confidence that the patient is actually going to receive that follow-up visit within the next seven days.

This really gets at community work and community engagement, so that you start to know your community partners well enough to know which ones are reliable about following through on the care recommendation you are giving, and which ones aren't. Or, if they push back against her care recommendations, that might make it default to collect this measure or report on this measure, but might yield useful set of discussions that ultimately yield much better care for the patient. That's what this is about. The measure - - not being 100% on measure, but having a conversation with the next side of care so that you know patients getting appropriate care. So, that's where this structure comes from and why we are asking that you have that warm handoff to the next side of care that you reach a point where you are comfortable with that community partner, such that you think they're going to act on your recommendation. That comes out of the desire to see these relationships function successfully for the sake of the patient. Do want to add anything, Laura?

If you are discharging patients to a skilled nursing facility and discharging them to a skilled nursing facility A and you tell them at facility A that this patient is at high risk of readmitting and need to be seen by position and seven days and you know that -- you know facility A and you have evidence and of seen that they are, indeed, going to get that appointment happen within seven days, count that in this measure. If you discharged to facility B, skilled nursing facility B down the road, and you don't have as good communication with them and may tell them that the patient doesn't high risk for readmitting and needs a follow-up follow-up appointment within seven days. When you tell them that, facility B may say, you know we don't have a medical director right now. Will do the best we can. We will get them and when we get them in. You can't count that one is having the follow-up visit scheduled. That wouldn't be account. That would be a red flag that you need to do relationship development and follow-up and help for that skilled nursing facility. On one hand, if you look from the measurements side, it might look like I'm getting dinged for something outside my control. Well, maybe. We want to frame this more as, again, like Erica said, we don't want you to ace this measure. It's not about getting 100% on this right off the gate. It's what where you need to apply the work to improve those transitions and make this happen. That is one example of what we can't have what we don't count.

Yes. That's exactly what I'm thinking, thanks, Laura. I don't see questions coming in. Feel free to chat them in.

We talked about two measures so far. We talked about the outcomes side and we talked about readmission rates of the hospital level and readmission lakes at the unit or population level and then we talked about her process measures is that you need to be able to assess those patients that are high risk and the high-risk patients you do have need to be receiving a follow-up visit within seven days. The other intervention is a follow-up bone call that says high-risk patients -- high-risk patients within three days. They found some really remarkable results from making those phone calls work certainly out there in the literature and best practice. It's something we have seen independently in North Carolina as effective. We bring it to the collaborative. The measure will be of the
number of high-risk patients that receive a follow-up phone call or home visit within three days of discharge. Divided by the number of high-risk patients on the pilot unit or population.

A couple of comments on that measure. Patients who die in the hospital are not included. It takes three business days. If a patient is discharged to the next side of care, they can be counted as having received a phone call, provided the next side of care is informed if the patient is at high risk of readmission. Having that communication flow, when you talk -- if the patient was discharged home, and the patient would receive a follow-up phone call about what kinds of things to keep on the radar. What's needed to keep you from bouncing back to the hospital. If the patient is discharged to the next side of care, you have that phone call with the next side of care about how to take care of the patients. The patients at high risk that you may need to keep an extra on an act slides each year. You can count that is equivalent to making a phone call for patient.

As we talked with other stakeholders, of course sometimes a party other than a hospital makes it possible for making phone calls. You may contract with someone or have a care manager on site from another organization that makes some of these calls. The call as having been made, and provided you've done due diligence with the third-party. Very similar. It's a measure where we said that you need to make sure, to a little bit of work with your community partner to make sure that the follow-up care is happening.

The last comment was ideally you do best practices when you make these phone calls, such as what is the best time to call as opposed to calling at the time it -- the time most convenient for the workflow in the hospital, so that you are successful in making the call happen.

We see a question coming in about residential hospital -- hospice, being excluded. I don't know the answer right now. It's a really good question and what I will do is write it down. I'm going to edit down and get back to you. If anyone else in the group wants to chat in on this issue, you should do that, as well. I have a slide later on where I say how useful it is to get questions like this. Particularly, questions about exclusions or how to handle special cases, or a relationship in your hospital where you look at this measure and you think it doesn't apply. We want to hear that. Some of the measures are new this year, so we need to hear that. We want to hear it before June 18, before your in person. Your homework as to think about what these measures mean for you on whether the makes sense, whether they're useful and if you have questions or feedback, to get it to us before the in person on June 18, so that we have time to do homework on our end. We talk to our stakeholders to come back to you. When you hit your first data entry, wishes in July, like 20, these kinds of details have been worked out and you have time to put a data system in place. I like the question I want to encourage others on the call to be thinking about similar kinds of questions. Hopefully, get them to us by around the June 18 timeframe so we can do our homework on our end, as well.

The last process measure I will talk about his patients who cannot be reached. If the number of high-risk patients who were called to were more times but could not be reached for follow-up phone call or home visit within three days of discharge divided I the number of high-risk patients on your unit.
It includes patients who die in hospital. It can be to help your hospital evaluate the success of reaching patients by phone. Are you having challenges to get the phone calls made reliably? Is there implementation challenges there? Or, are you making the calls and many of your patients are not reachable? If you have a low% of patients who are receiving a follow-up call within three days, there could be two reasons for that. It might be that the reason you are only reaching 20% of your patients within three days is because you are not making the phone call, or it might be because you are trying, but the patients are unreasonable -- reachable. The way you fix that is very different. You can work on your process of complaint, you might have to work on the staffing, how to get at her phone numbers from the patients. It depends on what the problem is and you don't want just to measure the percent of high-risk patients within the follow-up phone calls, without also measuring the barriers. It also helps to benchmark against each other a little bit because if you have 50% unreachable patients, there are going to be differences in patient populations that will affect reachability. There might also be lessons learned that can be served across the collaborative. This measure will help us identify good opportunities.

That is all the measures. This is a summary slide with the six measures, two outcome measures and four process measures, as well as the goal for your hospital. As Laura said, the goal is not to ace these measures in the first month or necessarily even to ace them in the last month of the collaborative. The goal is to make meaningful progress on each of these measures.

I encourage you -- I wanted to have it on one slide so in case you need the screenshot, you will put it on the bulletin board.

As I mentioned earlier, questions, comments. Some of these measures are new. There things we haven't thought of, even frankly for the older measures. We have on through rounds of feedback with the hospital, that the actual measure users, they are the most valuable you can get. Very much welcomed. Please, if you can get us that feedback before June 18, that will give us time to get the answers for you before your first meeting on July 20. Questions can go to your coaches, to Laura or myself. All those roads will lead to the same place if we all talk to each other on a regular basis. I see a comment. The comment pointing out that reaching patients often depends on having the conversation with patients about why we want to contact them after their hospitalization. Hope identify opportunities to present readmissions. Conversations to define the best time to call, as well. One of the things is as you look at what percent of patients are quote unreachable, there are opportunities to have these conversations, to explain why it's important to have this phone call, so that they are more productive and actually do what you want them to do, which is to reduce your readmission rate at the end of the day. It's getting back to why we bother to do any steps at all, why we measure this. We want to do these steps to make these changes in ways that reduce our readmission rates and that means having affect the phone calls, not just checking off a box.

A follow-up on that, too, it's a really good point of making the phone call is effective and meaningful as possible and not just a checkbox. Rick knowledge it's hard enough to get those call made any which way, let alone do them well. But it's going to serve you to do
them well and in order to do them well, you need to talk to that patient upfront, as was mentioned, to find out when a good time to call us and who you should talk to, you or your family member or other caregivers. What number would you prefer to use? If all that conversation happens early on and a patient's administration, as part of that assessment and planning, you are more likely to have an effective phone call it the other end rather than something that is just oh well, we are going to check the box and move on. That would help you.

Having the more difficult conversation to build the pieces in your patient assessment will help you.

If you monitor your readmission rate to the hospital unit or population, you can try having conversations with patients, working intensely that you can actually see if it pays off in three months. Does it off in one month? You can really look at whether or not, as an intervention, it is working. I'm not sure if I understand your question about June 18. You can say a little bit more about that question. Or, follow-up with me afterwards.

I'm thinking maybe she wonders when we stop collecting the cohort to measures and start collecting cohort three measures.

That may be. To have -- the calendar in my head is broken.

[Laughter]

Do have that information on the top of your head?

I think June is the last submission deadline.

That is my instinct, as well.

The goal should be that July 20 will be the switchover to the new measures.

She says she thinks it's a trend of process opportunities for improvement from the calls for patient. It's good to look at the trends that are identified. If you see in the first month that 80% of your patients are unreachable, it tells you might have a big -- an opportunity to make that context happened.

We will be able to provide resources through coaching and some of the educational pieces with the collaborative. As you begin to do that and then cover reasons why, we can help you analyze that. I can't reach 50% of my high-risk patients. Hope to figure out how to dig into that in a way, Web learn something and find something we can fix. We will provide resources and you all will provide resources back and forth to one another as he get into doing this.
Little bit more on the detailed data submission timetable. The process measures are due July 20. That will be June discharges. On subsequent submissions, they are monthly. The 20th of each month. At should, I wrote July 20 because it's always the 20th of the month. It's a Sunday, so per our general requirement, the 20th falls on a Saturday, a Sunday or holiday, then it gets an extension to the next business day, the 21st. Generally, you want to have that ticker in your head is the 20th comes around. That is when it's due. For the readmit rate the unit a population, your first date of submission is August 20. You will have the opportunity to do April, May and June data as record guys. You may not have the April data. It's brand-new for your hospital. I encourage you, if you can get the April May and June date, put it in.

It's also okay to submit back to 2010 if you desire to do so. Subsequent is a monthly timeframe.

Some hospitals indicated they will only be able to get that report on a quarterly basis. Quarterly is better than nothing. Go for that, as well. It's ideal that you have it monthly, so you can make tweaks to your process each month as you look at whether your rates go up or down. If you make those tweaks based on your best sense of what's going on and quarterly look at the data to validate what you think is going on is going on, that's also a reasonable way to run the project. We all have limited resources.

You might -- you may have noticed on the left slide, the process measures, that it's due July 20. The readmit rate, your June data is due August 20. That can be confusing. Why is that? Basically, your readmit rate requires a 30 day look forward period. What that means, if you have a June discharge, they might readmit any time in the month of July. Any time in the next 30 days. That takes you all the way through July. If I were to ask for your June readmission data on July 20, I would ask for it too soon. What about that patient -- what if that patient readmit? You will not know on July 20. Instead, you have to bump your submission date to the next month, to August 20. That's why there's always going to be a 30 day look forward period and a slight offset between when your process measures are due, which month they are due in and your outcome measures.

Was that clear? I am looking around the table, here. I should mention, by the way, that these time frames -- we will talk about the data manuals. The due dates for every Pease of your data are in your data manual. What is due July 20, what is due September 20. You won't just have this slide to go on. You will have a whole calendar of due dates.

How to submit data? Those who up in with us before, you know we have quality data, the URL. It's the web-based portal. Data is numerators and denominator only. For each month or measure, you enter two numbers. Don't enter patient level data the way you do another systems.

This screenshot -- this is what it looks like when you log into the system. Click on the data entry, the heart rate monitor. For data entry, you may not see all these other modules such as the adverse events. You probably aren't enrolled in that. That's okay. You should only see the projects you are actually a part of. Once you click on the data entry icon, you will be back to a page where you show -- Tuesday or measured set.
Choose readmission collaborative 2014. There are several readmission collaborative currently listed. Those roll off as they close data entry. It can be confusing in the first month or two. You see multiple entries. You need to remember you are readmissions collaborative 2014. If you enter your data in the wrong place it still ends up in the data system, but what happens is you will also find it. You will get confused because after entering your data review realize not all the measures are listed of there. That's because you are in the wrong module.

Your data will be lost, but you will be able to enter everything you want to enter to the readmissions collaborative 2014.

Besides the label of 2014 versus 2013, the dead giveaway is the new measures listed Turkey will see the new measures.

If you printed your list, the six measures, you will see the same measures, or you will see some very different sets. If you see a different set, you are in the wrong place. Try one or the other work go back and we select.

When you do get into the right readmissions collaborative, 2014, you will see a screen that looks something like this. It's a numerator/denominator. One number on top, one number on bottom. The first measure indicates how you are doing on that measure.

I say question about the NC Quality Center. You partner because we built this data port. Building a data port is not a small endeavor. It's a large and today. It's one of the ways that we provide the IT support. It's a full partnership, and I regard.

The think we've talked about what measures should be entered and why those measures are important. We talked about how to enter them, and now we want to talk about what resources we provide to help you through this process. The data manual will be on our website next week. The data manual, this is a screenshot from the table of contents. You can see there's a lot of stuff in there. There's an overview table. The first couple of pages have an overview. If you are the project lead and not the data person, you might be interested in the first -- the graphs on the first three pages. They tell you, generally, what is measured and planned of the project. There is a detailed timeline in there. What is due September 20, October 20, etcetera.

Then, we have detail on all the different measures. If you wonder how the measure is defined and when and where to submit it, that will be in there, as well.

At the back, you have a couple of general resources including some of the things I point out, the FAQ section. Teams, a glossary of data terms. Wondering what is what, you can look that up in there. There is a step-by-step guide if you get turned around. That is there, as well. The other one I wanted to point out is the performance monitoring plan. I will talk more about that in a moment.
First, I wanted to show you where and the website you click to get to the data manual. It's not the first thing on the website. It's down under featured resources and there will be one resource which is featured. Right now, an executive summary. You will want to click on the view additional resources tab to take you to their page. It has all the additional resources on the site. I don't know if we are planning to feature this resource or not. 

It would be good to feature it.

We will feature this for a while, but after that, long-term, know that the one or two resources which are featured are not the entirety of the resources. Feel free to click on that so you can see the rest of the resources provided.

For the hospitals, we usually send a link directly to the patient. You are use to the look and feel of the toolkit pages. It's the same page, the resources page you are to going to.

Resources, it provides the data manual and there's another important resource. It's word-of-mouth, or just talking to people. Talking to us that NoCVA or the coach. Also, talking to each other. When they billed the report, that IT system to pull the data and they find it really useful or develop a standard of work around collecting and sending a note to the listserv to share that. Even if you don't have the time to write up exactly what they did, sending something out that said we've been working on this. Contact me if you have questions. That context -- puts you in contact with someone who is working on a similar kind of problem. Feel free. To the extent we don't each have to build -- build things from the bottom up. We can stand on each other's shoulders. We want to utilize each other as much as possible.

The other resource I will mention, is that we do provide monthly feedback reports. They start July 30. They look something like this. They have each measure in the project. In this collaborative, it has a run chart that shows you where you are with current performance is what the goal is. The collaborative average, as well. I am running low on time. I'm going to say couple of last things about how to make the debtor work -- data work for you.

I live in the data lab day today. I spend a fair amount of time -- it's really for two things. I think of you of you as having two jobs. One is how to collect and report on these data elements. You are responsible for submitting five different measures to us and probably thinking, how will I ever get this out of my system? Who is going to do what? Who was going to enter the data in. Were thinking about all that. Check the box off that you got the data done.

What are want to encourage you to do, is to think about that stuff. We spent time thinking about what to do to make the data meaningful to our PI efforts. How to get beyond checking the box and submit it. It's down. It's off my chest. Making the data useful. Not just generating another report. Having time for something on your desk that has a piece of data. I want to encourage you -- and I'm guilty of this, as well. Tried to do a little bit of work on the front-end. Think about what the plan is for using it. If you go
through the process of collecting these different measures, how to make it actionable and share it back, etcetera. Couple of thoughts about that, on the data side, you might be thinking about where and how to report this. What I want to take from the readmission rates and the population? Do I want to share process measures to my staff? So the report doesn't just come back to you, the project lead or the data person. Somehow, it's used to connect with people around a project and have a conversation. You might also think about who is responsible for investigating the process or outcome measure gap. For instance, if you are calls are being made, you might want to assign someone for the responsibility to look at the process measure. If they see a gap, compactor team meeting and talk about why that gap is there.

Another thing is setting internal targets. Asking yourself, the goal is to be at 50% on this measure. It's one way of, again, forcing her team to have that conversation and structuring a conversation so that you keep your eye on the ball. One tool you might use if you try to think about how to make your idea actionable, is the performance monitoring plan at the back of your data manual. It's not a perfect tool, but it's a good example. For measure number three, getting patients assessed for high risk. You might say, I think my target should be getting the tools placed by July 1 and then assisting 50% of the patients by August 1. Get up to 95% by September 1. You may know those are ambitious goals, but it helps to have that conversation. In August you have a conversation with your team and say you want to get 50%, we are only 10%, with our realistic goal for next month?

Planning how you want to use your data to initiate discussion and how to initiate digging. What you want them to be, to really pay off in the long run.

That's my last general slide. It's a summary and talks about process and outcome measures. Two outcome measures, for process measures. What I want you to do, you get off this webinar and fresh in your mind, make your to-do list. How will I ever get my unit and population data rates? What initial questions do I have on the process measures truck who do I need to ask on my staff about these? Who's going to collect did? How do I use this data? Spend 10 minutes brainstorming on that.

How to use these measures. This is just sending them to us. This is a matter of send them to us to hold you accountable for gathering, so that you can use them for your own benefit. I want to jump in now to an overview of the activities of pre-work. We want to touch on all of the pieces, to make sure that you have them together for coming to the in-person learning session on June 18. We were hoping that by now everyone would have participated in a leadership assessment and review do that on the leadership 121 call. That would be a call with one of us from NoCVA with your team leader and your access - - your executive sponsor. That everyone has had that. Songs we can get that he for the in-person session, we will be happy. If you haven't yet scheduled one, know that you will be hearing with us at the quality center and we will help get you scheduled for that. You should have your project team together work it should be multidisciplinary, hospital level and unit level across continuum team. It should include some community partners. We would hope that by now you also have begun to develop your risk assessment and plans of the piloting or spreading of that risk assessment. If you use the risk assessment last year and are going to continue using it, howdy is spread that to the next unit? Howdy is spread that that house wide? Also, letting you know that this webinar is going to be
available on our website. It will be posted promptly. If you have team members that haven't seen them, they can go back and get a look at them. By the time you show up on June 18, you have completed the diagnostic assessment of five recent readmissions and that you've done a process map of discharge. If you have questions about how to do that, call us, or contact us. There's also the second pre-work webinar that is all about these topics. Develop your plan on how you will collect, submit and use your data. Have that and bring that with you to the learning session. They're going to do a few polling questions. In the interest of time, I'm going to skip over to show you the link to register for the in person learning on June 18. If the link is live, you can jump right in there and register for that. Very important that you try your best to bring more than one person and try your best to bring these pre-work pieces with you. They're going to be used at that session. It's going to be a hands-on session. While there will be educational content, there's also time to use your assessment with your team and do some real work at this session. You need to bring these things with you. You need to register more than just one of you and show up. We've reached the top of the hour and I want to thank you for your participation. If you've got additional questions, contact me or Erica or Dean. We will be glad to follow-up. These take another moment and complete the evaluation questions that will pop up at the end of the webinar. Thanks for hanging in there with us. We hope this was helpful and feel free to be in touch if you have any further questions about it.

This concludes the webinar. You can now disconnect.