Advanced Strategies in Hospital Pay for Performance

Frank Johnson, VP
Premier Healthcare Alliance

Jan McNeilly, RN, Director
Premier Healthcare Alliance

Premier Pre-Conference Agenda
Advanced Strategies in Hospital Pay for Performance

- **8:30 AM – Welcome and Introductions**
  - Frank Johnson, Vice President, Premier, Inc., Charlotte, NC
- **8:45 AM – Top Performer Strategies**
  - Jan McNeilly RN, Director, Premier Inc., Charlotte, NC
- **9:15 AM – Rapid Clinical Improvements for Hospital-wide Success**
  - Dan Grigg and Kristin Myers, Center for Patient Safety & Clinical Effectiveness, Salem Hospital
- **10:00 – Break**
- **10:15 – System-wide Approach to Clinical Improvements**
  - Ginny Ripslinger, AVP, Knowledge Management, St. Joseph's Health System
- **11:00 – Unique Improvement Tools from an HQID Top Performer**
  - Lori Knitt, Director of Medical Staff / Quality Services, Aurora Sheboygan Memorial Hospital
- **11:45 – Next Steps in P4P – QUEST: High Performing Hospitals Program**
  - Frank Johnson, Vice President, Premier, Inc., Charlotte, NC
- **12:00 – Adjourn**

Top Performer Strategies

CMS/Premier
Hospital Quality Incentive Demonstration (HQID) Project

February 2008

Jan McNeilly, RN, FACHE, CPHQ
Director, Client Services
Informatics
Premier, Inc.

Session Objectives

- Provide strategies from year 3 Hospital Quality Incentive Demonstration (HQID) top performers, focusing on:
  - Leadership
  - Physicians
  - Nursing
  - 5 populations
    - AMI
    - CABG
    - Hip / Knee
    - Pneumonia
    - Heart Failure

Year 3 Top Performer Highlights

- Consistent with Year 1 top performers
  - Leadership priority
  - PI department very involved
  - Concurrent review and intervention
- New lessons in Year 3 of the project
  - Wide-spread physician engagement (more than a few scattered physician champions)
  - Adoption of standard order sets –based on patient condition NOT based on physician preference
  - Process embraced by nursing with some processes being spread to all patients
    - "if vaccinations are important to this population, why aren't we doing it for every patient?"

Leadership is a Priority

- What does that mean?
  - Board Quality Committee – same meeting frequency as Board Finance Committee
    - ✓ Quality is first on the “big Board” agenda
  - Senior leaders have detailed knowledge and participate on clinical teams
    - ✓ Can articulate clinical process issues
  - Incentive programs in place
  - Expectations clearly articulated to the medical staff
  - Resources are provided to support performance improvement

Leadership cont.

- Priorities for improvement established and monitored via a balanced scorecard
  - Priorities cascade to departments
    - ✓ Pharmacy – PN antibiotic timing, CABG antibiotic stop
    - ✓ Nursing – vaccines, discharge instructions
    - ✓ ED – PN antibiotic timing, AMI door to balloon
  - Included in Performance Evaluation process
- Structure of Accountability
  - Expectations communicated
  - Progressive intervention when expectations not met
- Reward and Recognition

Leadership: System approach – Aurora

- Balanced metrics for clinical priorities
  - Core measures (system's #1 priority was HQID)
  - Cost
  - LOS
  - Mortality
- Networking among the 13 hospitals
  - Standardized order sets
- HQID and CPR's on all management incentive plans

Aurora's #1 Priority

Our patients deserve and expect the best care. We will give people better results than they can get anywhere else by achieving top performance in all our quality measures.

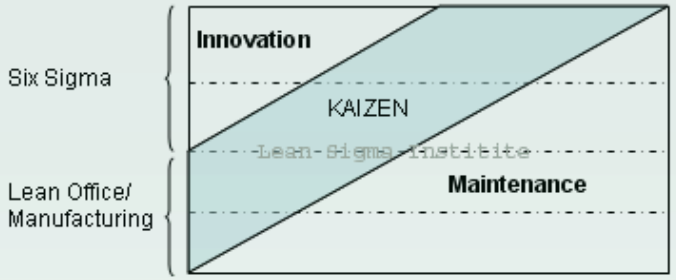
For Aurora, there is no alternative

Aurora Created Lance Armstrong-style Arm Bracelets for Staff

Leadership - Infrastructure

- Improvement methodology
  - Most hospitals have a methodology because of accreditation requirements
  - Mix of methodologies used by top performers
    - Six Sigma
    - PDCA
    - Home grown
  - Quality Departments serving more as facilitators and process improvement experts rather than being responsible for making improvements

Six Sigma



PDCA

Concurrent Monitoring - General

Strategies in place at all top performers visited to date:

Note: 2 had previously used Care Management staff for this function but stopped due to LOS “creep”

- Case finding
  - Daily census (sometimes special ones created by IT)
  - Customized daily alerts from lab, pharmacy and radiology
    - Troponin, BNP, Lasix, chest x-ray/pneumonia
- Reminders and Alerts
  - Everyone’s using reminder forms on the charts
  - Purple is the “hot” color
  - Not part of the permanent record

Physician Engagement

- **Increasing involvement**
  - Active participation by at least one physician champion
  - Physician-to-physician communication and "negotiation" regarding performance
  - Specialists, such as Infectious Disease physicians, help educate/explain rationale for measures
  - Expectations built into contracts for paid physicians
  - Physicians receive "report cards"

Order sets

Varying approaches:

1. Mandated use of hospital's order set

   "If you want to work here, you use our order sets"

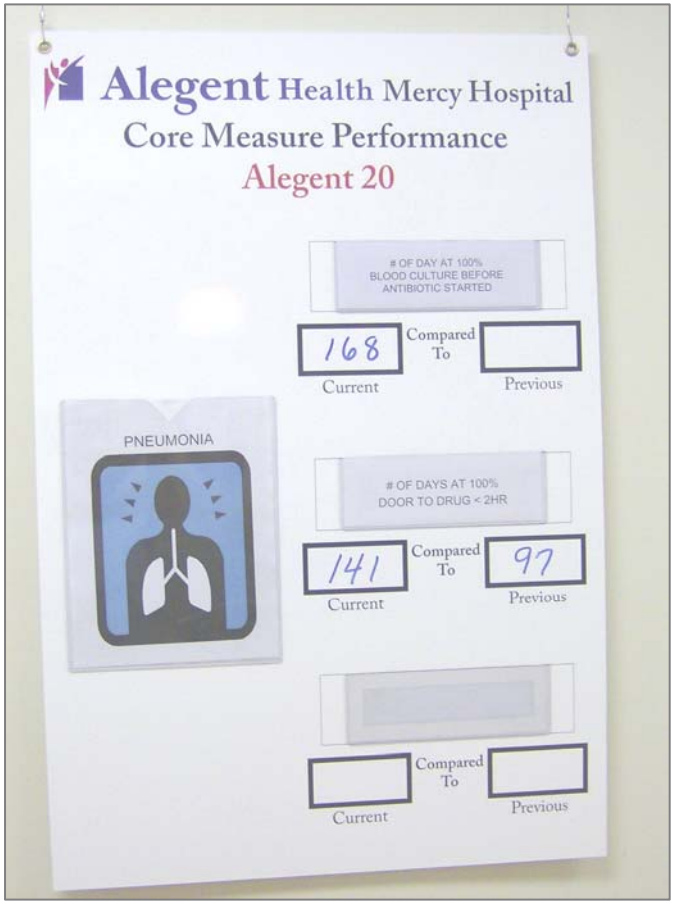
2. Physician-specific orders allowed
   - Must include process measures
3. No mandate, but every failure to meet evidence based care results in an automatic peer review case
4. Standardized across the system
   - PDF order sets posted on intranet
   - Ability to rapidly implement modifications
   - Incorporates additional requirements such as IV to PO switch orders for antibiotics in pneumonia patients

Nursing Engagement

- Nurse managers assume responsibility for monitoring patient-specific worksheets
  - Progressive intervention when measures not met
- Core measure information being included in most orientation programs for new nurses
  - Mercy – Alegent
    - Conducted 2 hour training for all nursing staff with copies of actual patient charts
    - 2 hour session scheduled for all new orientees to review core measure requirements and conduct abstraction exercise on copies of patient charts

Communicating results

- Provide status reports to all involved departments/units
- Avoid posting small text reports
  - Excel spreadsheets
- Use the “United Way” method of displaying status and targets



Five clinical areas

Top performers identified in:

1. Acute Myocardial Infarction
2. Congestive Heart Failure
3. Coronary Artery Bypass Graft
4. Hip and Knee Replacement
5. Community Acquired Pneumonia

Rapid Improvement Programs

Smoking Cessation Counseling

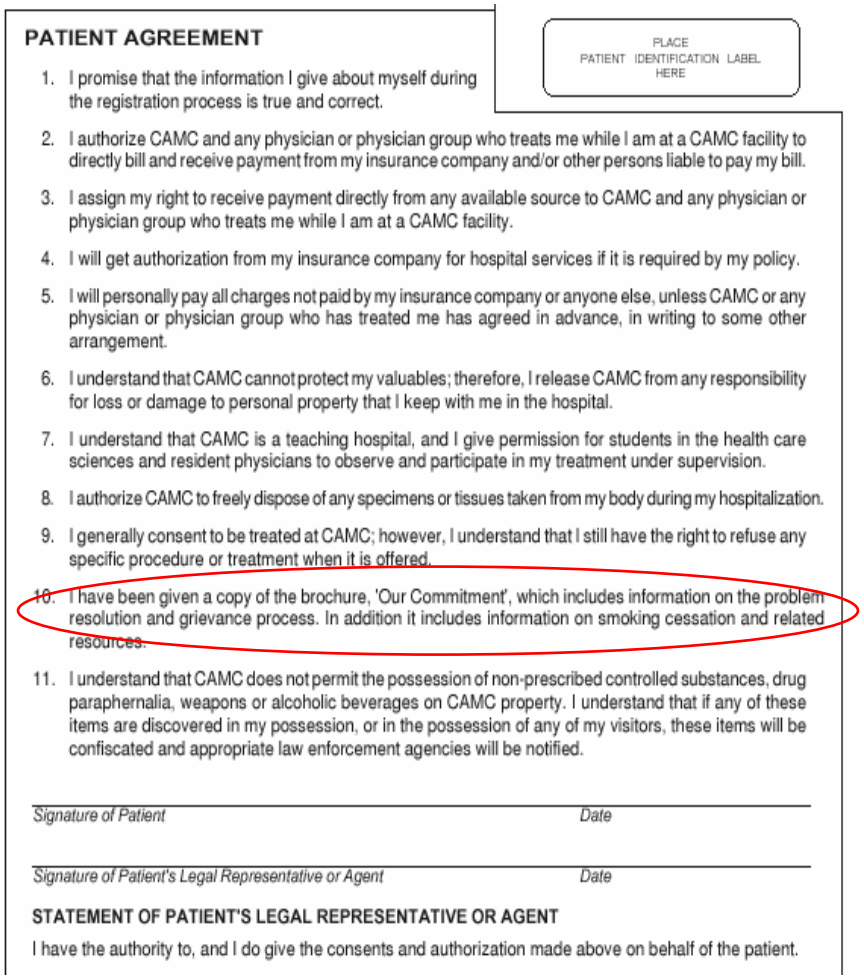
Specific Interventions of top performers

Smoking Cessation – Getting to 100%

1. Don't start your process by trying to find the smokers!
   - Relies on thorough questioning during nursing assessment
   - Patients sometimes don't admit to being a smoker

2. Make it apply to every patient
   - Everyone can benefit
   - Provide education material in the admission packet or in the discharge packet

3. Do offer cessation classes/intervention to smokers



PATIENT AGREEMENT

PLACE PATIENT IDENTIFICATION LABEL HERE

1. I promise that the information I give about myself during the registration process is true and correct.
2. I authorize CAMC and any physician or physician group who treats me while I am at a CAMC facility to directly bill and receive payment from my insurance company and/or other persons liable to pay my bill.
3. I assign my right to receive payment directly from any available source to CAMC and any physician or physician group who treats me while I am at a CAMC facility.
4. I will get authorization from my insurance company for hospital services if it is required by my policy.
5. I will personally pay all charges not paid by my insurance company or anyone else, unless CAMC or any physician or physician group who has treated me has agreed in advance, in writing to some other arrangement.
6. I understand that CAMC cannot protect my valuables; therefore, I release CAMC from any responsibility for loss or damage to personal property that I keep with me in the hospital.
7. I understand that CAMC is a teaching hospital, and I give permission for students in the health care sciences and resident physicians to observe and participate in my treatment under supervision.
8. I authorize CAMC to freely dispose of any specimens or tissues taken from my body during my hospitalization.
9. I generally consent to be treated at CAMC; however, I understand that I still have the right to refuse any specific procedure or treatment when it is offered.
10. I have been given a copy of the brochure, 'Our Commitment', which includes information on the problem resolution and grievance process. In addition it includes information on smoking cessation and related resources.
11. I understand that CAMC does not permit the possession of non-prescribed controlled substances, drug paraphernalia, weapons or alcoholic beverages on CAMC property. I understand that if any of these items are discovered in my possession, or in the possession of any of my visitors, these items will be confiscated and appropriate law enforcement agencies will be notified.

Signature of Patient *Date*

Signature of Patient's Legal Representative or Agent *Date*

STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I have the authority to, and I do give the consents and authorization made above on behalf of the patient.

Rapid Improvement Programs

Vaccinations

Specific Interventions of top performers

Vaccinations – Getting to top decile

- Nursing owns the process
  - Medical staff approves protocol allowing nurses to assess and administer
  - System of accountability with progressive intervention
- Apply process to all patients, not just CMS conditions
  - “if this is good for pneumonia patients, why aren’t we doing it for all of our patients?”
- Maintain internal tracking system so nurses can check vaccination status
  - Staff authorized to proceed with vaccination ONE TIME if history isn’t available

Heart Failure

Specific Interventions of top performers

Heart Failure – Key Strategies

- Timely identification of HF patients
  - Check previous admissions for history of HF
  - Get daily lab report with BNP results
  - Get daily pharmacy report – anyone on lasix
  - Radiology sends alert to concurrent review staff if chest x-ray shows HF
- Discharge instruction form specifically for HF
- Discharge “time out”
  - Two nurses review and sign the discharge forms
- Monitor missed cases – physician counseling/education (or peer review) when HF not identified during stay, but coded at discharge

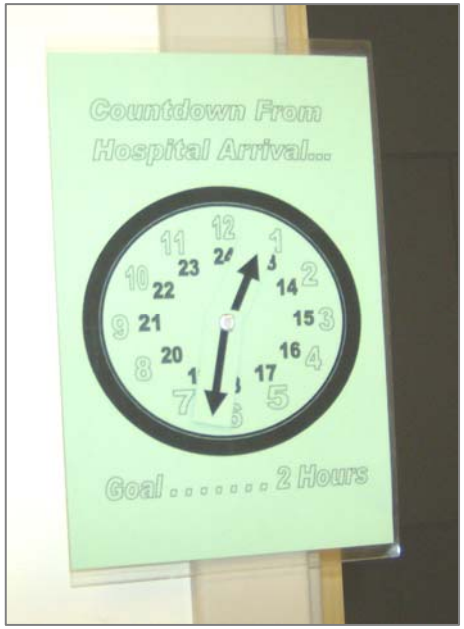
Rapid Improvement Programs

Pneumonia

Specific Interventions of top performers

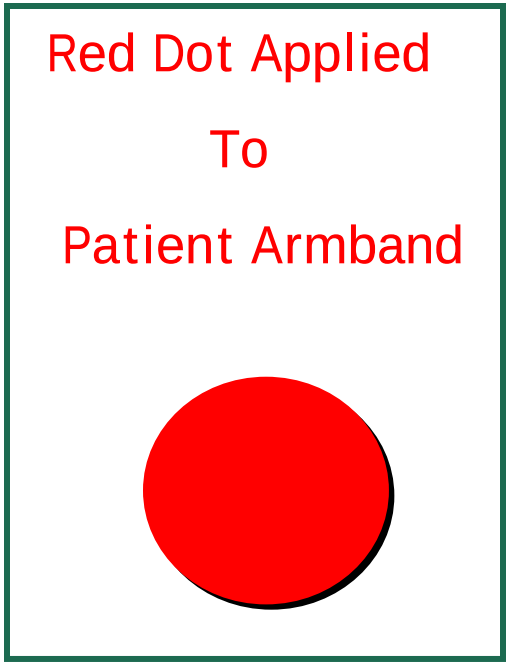
Pneumonia – key strategies

- Rapid diagnostics especially chest x-ray
  - ED triage protocols
  - No patients sitting/waiting in ED
  - No patients sitting/waiting in Admitting
- Rapid physician access to film
  - Radiology responsive
  - System in ED to track availability of film
- Method for monitoring time status while patient in ED
  - Electronic board – flashes red when 3 hours reached



Pneumonia – key strategies

- Blood cultures
  - If Pyxis machines – “got blood culture?” stickers on antibiotics
  - White boards in patient rooms with blood culture section
  - Red dots placed on patient ID bracelet
- Rapid Access to antibiotics
- Antibiotic Selection
  - P&T formulary
    - Infectious disease physician has to approve variances
  - Reminders
    - Pocket cards, printed lists hanging on units



Acute Myocardial Infarction

Specific Interventions of top performers

AMI - Strategies

- Rapid diagnosis – EKG
  - Set standard – “EKG within 6 minutes of arrival”
  - Alternate strategy 911 responders equipped with EKG with transmission capability
- ED physician “in charge”
  - One page alerts the entire team
  - Only interventional cardiologists
- ED nurse transports patient to cath lab as soon as cath lab nurse arrives
  - Stays and helps get patient ready
    - Undress/into gown

Rapid Improvement Programs

SIP: CABG and Hip & Knee

Specific Interventions of top performers

Preoperative Antibiotics – Getting to top decile

- Anesthesia must own this
  - Last “line of defense”
- Include on the surgery “time out” list of questions
  - “pause for the cause”
- Modify Anesthesia record to prompt appropriate documentation
  - name of drug, dose, route, time, who administered
- Some hospitals including this requirement and performance expectation in anesthesia contracts

Discontinuing post-operative antibiotics – Getting to top decile

- Involve internal expert - Infectious Disease physician
- Include default standard order on all post-op orders
  - Include “why not” reminder to prompt surgeons to document rationale, if they extend the administration
- Have recovery room staff specify specific times for post op doses
  - Make sure pharmacy doesn’t assign administration times to match hospital’s standard dosing/times
- Some sites moving to q6 hr instead of q8hr administration
- Some sites moving from 3 post op doses to 2

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Rapid Clinical Improvements
For Hospital-wide Success

Dan Grigg
Director, Center for Patient Safety and Clinical Effectiveness
Salem Hospital – Salem, Oregon

Initiating Change

Why is changing health care so hard?
Why are science and practice still so far apart?
~ *Don Berwick, MD*

The Institute for Healthcare Improvement (IHI) uses a simple mantra to describe the essential elements for strategic improvement: Will, Ideas, and Execution. You have to have the *will* to improve, you have to have *ideas* about alternatives to the status quo, and then you have to make it real — *execution.*

Tom Nolan

Will, Ideas and Execution

- Will:
  - Necessary resources are made available
  - Naysayers are not allowed to block good ideas
  - Connection to strategic goals
  - Executive and Board attention
  - Buy-in from line managers , physicians and staff
  - Sufficient time
  - Elimination of competing priorities

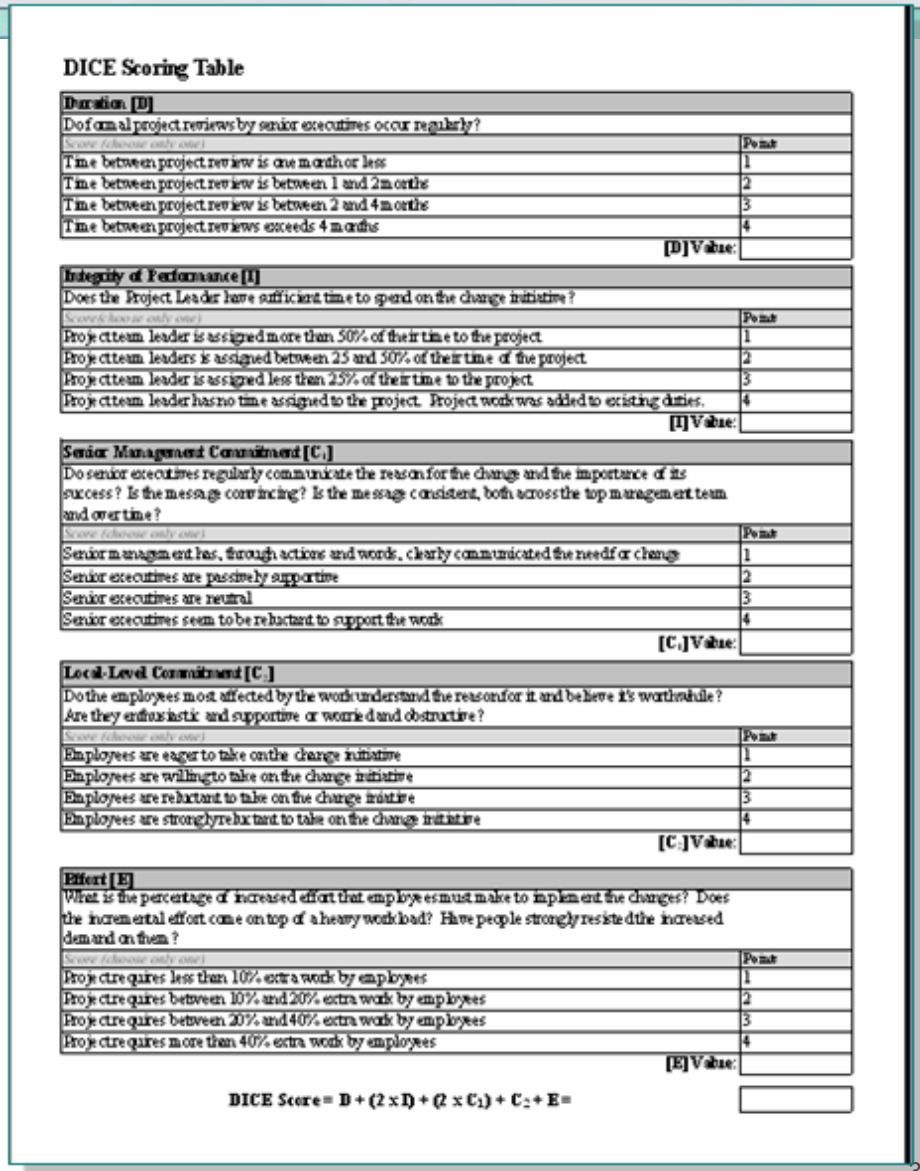
- Ideas:
  - Look outside to find best practices
  - Big ideas – radical vs. safe
  - Best in the world

- Execution:
  - Strong project setup and project management
  - Prepare for spread from the outset
  - Consistent change leadership framework
  - Spreadable

Will: DICE Scoring Tool

- Senior Leader Review
- Project Leader Time
- Senior Leader Commitment
- Local Level Commitment
- Effort to Make Change

Adapted from “The Hard Side of Change Management” October 2005 edition of the Harvard Business Review, written by Harold L. Sirkin, Perry Keenan, and Alan Jackson



DICE Scoring Table

Duration [D]	
Do formal project reviews by senior executives occur regularly?	
Score (choose only one)	**Point**
Time between project reviews is one month or less	1
Time between project reviews is between 1 and 2 months	2
Time between project reviews is between 2 and 4 months	3
Time between project reviews exceeds 4 months	4
[D] Value:	

Integrity of Performance [I]	
Does the Project Leader have sufficient time to spend on the change initiative?	
Score (choose only one)	**Point**
Project team leader is assigned more than 50% of their time to the project	1
Project team leaders is assigned between 25 and 50% of their time of the project	2
Project team leader is assigned less than 25% of their time to the project	3
Project team leader has no time assigned to the project. Project work was added to existing duties.	4
[I] Value:	

Senior Management Commitment [C_1]	
Do senior executives regularly communicate the reason for the change and the importance of its success? Is the message convincing? Is the message consistent, both across the top management team and over time?	
Score (choose only one)	**Point**
Senior management has, through actions and words, clearly communicated the need for change	1
Senior executives are passively supportive	2
Senior executives are neutral	3
Senior executives seem to be reluctant to support the work	4
[C_1] Value:	

Local-Level Commitment [C_2]	
Do the employees most affected by the work understand the reason for it and believe it's worthwhile? Are they enthusiastic and supportive or worried and obstructive?	
Score (choose only one)	**Point**
Employees are eager to take on the change initiative	1
Employees are willing to take on the change initiative	2
Employees are reluctant to take on the change initiative	3
Employees are strongly reluctant to take on the change initiative	4
[C_2] Value:	

Effort [E]	
What is the percentage of increased effort that employees must make to implement the changes? Does the incremental effort come on top of a heavy workload? Have people strongly resisted the increased demand on them?	
Score (choose only one)	**Point**
Project requires less than 10% extra work by employees	1
Project requires between 10% and 20% extra work by employees	2
Project requires between 20% and 40% extra work by employees	3
Project requires more than 40% extra work by employees	4
[E] Value:	

DICE Score = D + (2 x I) + (2 x C_1) + C_2 + E =

Ideas: Premier Top Performer Practices

- Leadership priority
- Wide-spread physician engagement
- Changes embraced by nursing
- Structure of accountability
- Reward and recognition
- Concurrent review and abstraction
- Case finding strategies
- Reminders and alerts
- Application beyond core measure patients
- Medical staff ownership
- Medical staff leadership accountability
- Rapid diagnostics
- Red dots on patient bracelets
- Access to antibiotics

Will, Ideas and *Execution*

The will of participants in IHI's 100,000 Lives Campaign and the will, creativity, and perseverance of the participants in five years of the Pursuing Perfection initiative led IHI to conclude that *execution* is currently the weak link in the three-component chain of Will-Ideas-Execution.

- Tom Nolan

Execution

The Anatomy of Perfect Execution

Execution in Dance

- The dance is choreographed (design)
- Instructor teaches steps, feelings, counts using words and mental images (education)
- Instructor marks steps w/dancers – on the dance floor (education)
- Run through w/dancers on the dance floor (validate competency)
- Practice, practice, practice (measure conformance)
- Perform on stage in front of audience

Execution

vs

The Anatomy of Perfect Execution

Execution in Football

- The coaches design a play (design)
- The play is added to the “play book” (educate)
- Players study the play/play book (educate)
- Walk through with players on the practice field (validate competency)
- Run through with players on the practice field (validate competency)
- Practice, practice, practice – study film (measure conformance)
- Perform in game situation

Observations

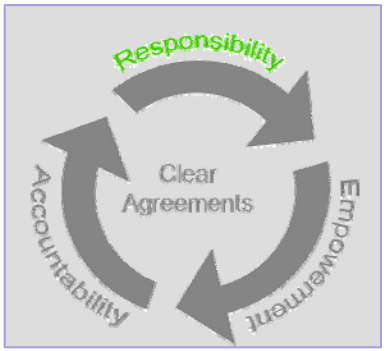
- Each process is intentionally designed to achieve a specific outcome
- In each case there is a transfer of knowledge – systematic process for communicating changes
  - One on one coaching
  - Group coaching
  - Playbooks/Bulletins
- There is consistent individual attention from a coach or supervisor throughout process
- There are opportunities to practice
- There are systematic process for verifying success of the implementation

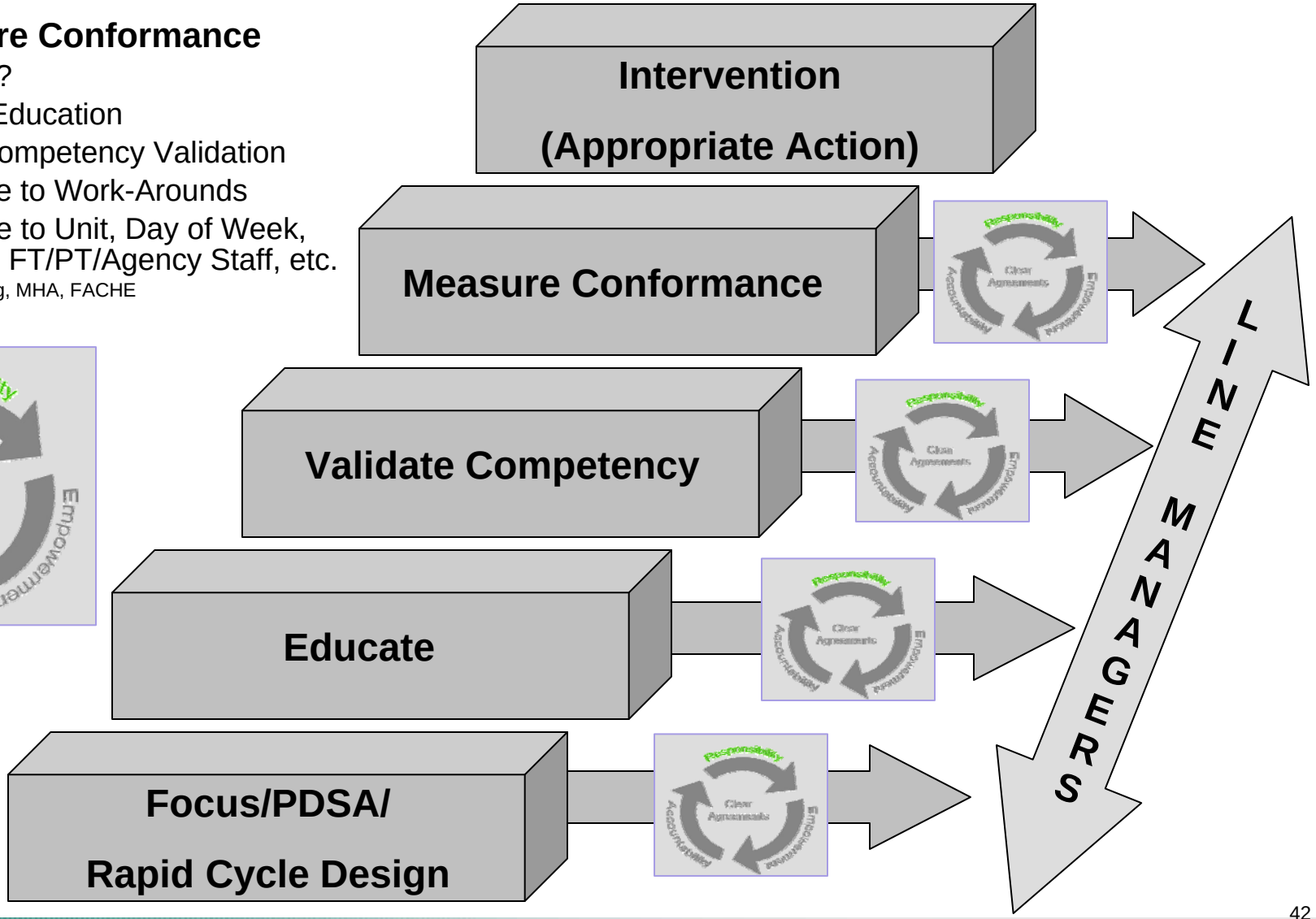
Salem Health 5 Step Execution Model

Measure Conformance

- Poor Design?
- Inadequate Education
- Ineffective Competency Validation
- Variation Due to Work-Arounds
- Variation Due to Unit, Day of Week, Time of Day, FT/PT/Agency Staff, etc.

Source: John R. Rosing, MHA, FACHE
The Greeley Company





Will, Ideas and Execution

- Left Ventricular Function Assessment
- Smoking Cessation Advice
- Antibiotic within 1 Hour of Incision
- ABX timing < 4 hours for Pneumonia
- Blood Cultures before ABX in ED for Pneumonia

Left Ventricular Function Assessment: Focus/PDSA/Rapid Cycle Design

- Problem:
  - Patients with heart failure were not consistently having LVF assessment
  - LVF assessment was not being addressed in chart documentation
  - Difficult to determine if it was being forgotten or not documented
  - Difficulty identifying Heart Failure Patients

- Design:
  - Green Reminder sticker implemented June 2007
  - Physician identification of heart failure patients November 2007

Left Ventricular Function Assessment: Focus/PDSA/Rapid Cycle Design

Reminder Sticker

This patient is being treated for exacerbation of HEART FAILURE

Check One: ☐ YES (If yes, please complete the following
☐ NO

Has left ventricular function been assessed?
☐ YES _____ mo / _____ year EF _____ % *
☐ NO – will be assessed during this admission
☐ NO – Assessment of LV function is not appropriate (see progress note)
☐ NO – Assessment of LV to be done as outpatient

* If LV function is < 40%, is the patient on an ACEI or ARB?
☐ YES
☐ NO – an ACEI or ARB will begin during this admission
☐ NO – ACEI or ARB therapy is not appropriate
☐ ACEI / ARB allergy ☐ Severe aortic stenosis
☐ Intolerant of ACEI / ARB ☐ Renal dysfunction
☐ Other: _____

Physician Signature : _____
Date: _____

Questions – HF Coordinator: Phyllis Anderson, RN – ext. 14166
HF Physician Champion: Kirk Walker, MD

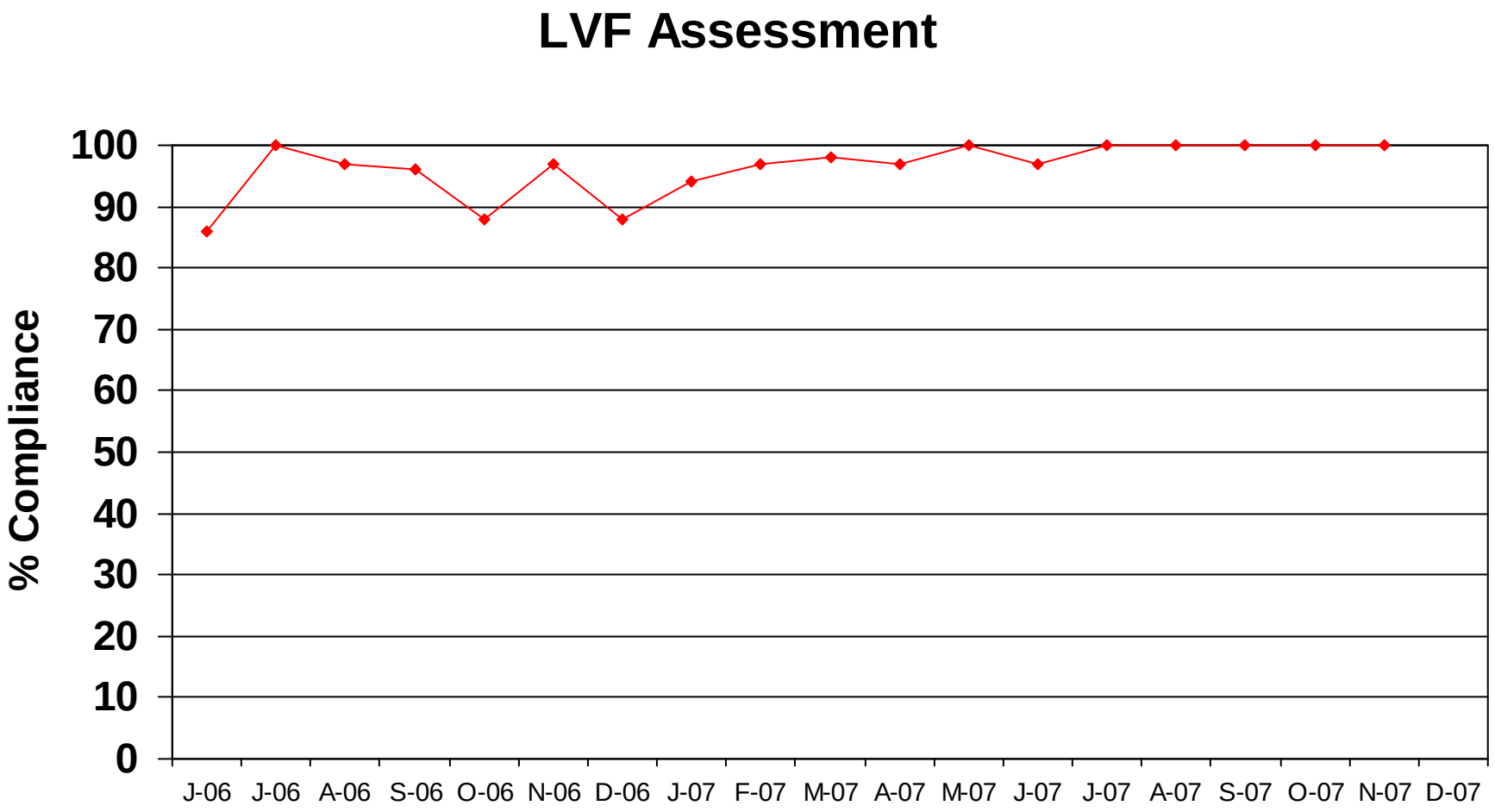
Left Ventricular Function Assessment: Educate

- Multiple physician lunches targeting top heart failure admitters
- Nursing education on floors where heart failure patients would be admitted
- One-on-one training for float pool and agency nurses
- Mandatory computer based training module developed and rolled out to staff
- Computer screen reminders to staff re: core measure elements

Left Ventricular Function Assessment: Validate Competency

- Concurrent monitoring by Heart Failure Coordinator
- Real time feedback and coaching given by Coordinator and Charge Nurse/Nurse Manager
- Real time feedback given to physicians by Coordinator with support from physician leaders

Left Ventricular Function Assessment: Measure Conformance

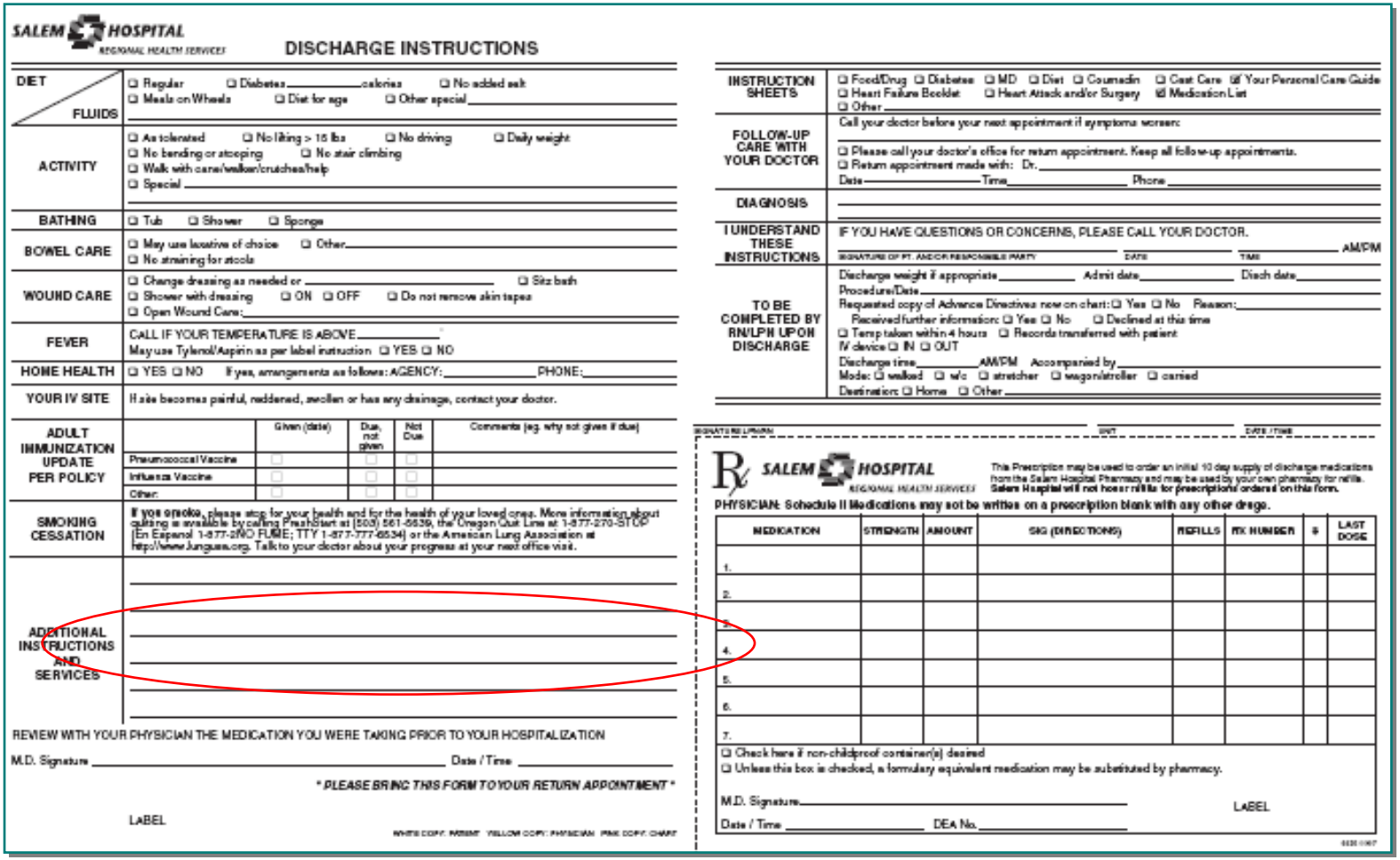


Smoking Cessation Advice: Focus/PDSA/Rapid Cycle Design

- Problem
  - Unreliable process to ensure patient received smoking cessation advice
  - Multiple resources available and multiple places in the record for documentation
- Design
  - Added smoking cessation advice to patient information booklet – given to all patients whether they smoke or not
  - Redesigned discharge instruction sheet June 2007

Smoking Cessation Advice: Focus/PDSA/Rapid Cycle Design

Discharge Instruction sheet



SALEM HOSPITAL
REGIONAL HEALTH SERVICES

DISCHARGE INSTRUCTIONS

DIET / FLUIDS	☐ Regular ☐ Diabetes _____ calories ☐ No added salt ☐ Meals on Wheels ☐ Diet for age ☐ Other special _____
ACTIVITY	☐ As tolerated ☐ No lifting > 15 lbs ☐ No driving ☐ Daily weight ☐ No bending or stooping ☐ No stair climbing ☐ Walk with cane/walker/crutches/help ☐ Special _____
BATHING	☐ Tub ☐ Shower ☐ Sponge
BOWEL CARE	☐ May use laxative of choice ☐ Other _____ ☐ No straining for stools
WOUND CARE	☐ Change dressing as needed or _____ ☐ Sitz bath ☐ Shower with dressing ☐ ON ☐ OFF ☐ Do not remove skin tapes ☐ Open Wound Care: _____
FEVER	CALL IF YOUR TEMPERATURE IS ABOVE _____ May use Tylenol/Aspirin as per label instruction ☐ YES ☐ NO
HOME HEALTH	☐ YES ☐ NO If yes, arrangements as follows: AGENCY: _____ PHONE: _____
YOUR IV SITE	If site becomes painful, reddened, swollen or has any drainage, contact your doctor.

ADULT IMMUNIZATION UPDATE PER POLICY		Given (date)	Due, not given	Not Due	Comments (eg. why not given if due)
	Pneumococcal Vaccine	☐	☐	☐	
	Influenza Vaccine	☐	☐	☐	
	Other:	☐	☐	☐	

SMOKING CESSATION

If you smoke, please stop for your health and for the health of your loved ones. More information about quitting is available by calling FreshStart at (503) 561-5536, the Oregon Quit Line at 1-877-270-STOP (En Espanol 1-877-2NO FUME; TTY 1-877-777-6534) or the American Lung Association at http://www.lungusa.org. Talk to your doctor about your progress at your next office visit.

ADDITIONAL INSTRUCTIONS AND SERVICES

REVIEW WITH YOUR PHYSICIAN THE MEDICATION YOU WERE TAKING PRIOR TO YOUR HOSPITALIZATION

M.D. Signature _____ Date / Time _____

** PLEASE BRING THIS FORM TO YOUR RETURN APPOINTMENT **

LABEL

WHITE COPY: PATIENT YELLOW COPY: PHYSICIAN PINK COPY: CHART

INSTRUCTION SHEETS	☐ Food/Drug ☐ Diabetes ☐ MD ☐ Diet ☐ Coumadin ☐ Cast Care ☑ Your Personal Care Guide ☐ Heart Failure Booklet ☐ Heart Attack and/or Surgery ☑ Medication List ☐ Other _____
FOLLOW-UP CARE WITH YOUR DOCTOR	Call your doctor before your next appointment if symptoms worsen: _____ ☐ Please call your doctor's office for return appointment. Keep all follow-up appointments. ☐ Return appointment made with: Dr. _____ Date _____ Time _____ Phone _____
DIAGNOSIS	_____
I UNDERSTAND THESE INSTRUCTIONS	IF YOU HAVE QUESTIONS OR CONCERNS, PLEASE CALL YOUR DOCTOR. SIGNATURE OF PT. AND/OR RESPONSIBLE PARTY _____ DATE _____ TIME _____ AM/PM
TO BE COMPLETED BY RN/LPN UPON DISCHARGE	Discharge weight if appropriate _____ Admit date _____ Disch date _____ Procedure/Date _____ Requested copy of Advance Directives now on chart: ☐ Yes ☐ No Reason: _____ Received further information: ☐ Yes ☐ No ☐ Declined at this time ☐ Temp taken within 4 hours ☐ Records transferred with patient IV device ☐ IN ☐ OUT Discharge time _____ AM/PM Accompanied by _____ Mode: ☐ walked ☐ w/c ☐ stretcher ☐ wagon/stroller ☐ carried Destination: ☐ Home ☐ Other _____

SIGNATURE UPON _____ UNIT _____ DATE / TIME _____

℞ SALEM HOSPITAL
REGIONAL HEALTH SERVICES

This Prescription may be used to order an initial 10 day supply of discharge medications from the Salem Hospital Pharmacy and may be used by your own pharmacy for refills. **Salem Hospital will not honor refills for prescriptions ordered on this form.**

PHYSICIAN: Schedule II Medications may not be written on a prescription blank with any other drugs.

	MEDICATION	STRENGTH	AMOUNT	SIG (DIRECTIONS)	REFILLS	RX NUMBER	#	LAST DOSE
1.								
2.								
3.								
4.								
5.								
6.								
7.								

☐ Check here if non-childproof container(s) desired
☐ Unless this box is checked, a formulary equivalent medication may be substituted by pharmacy.

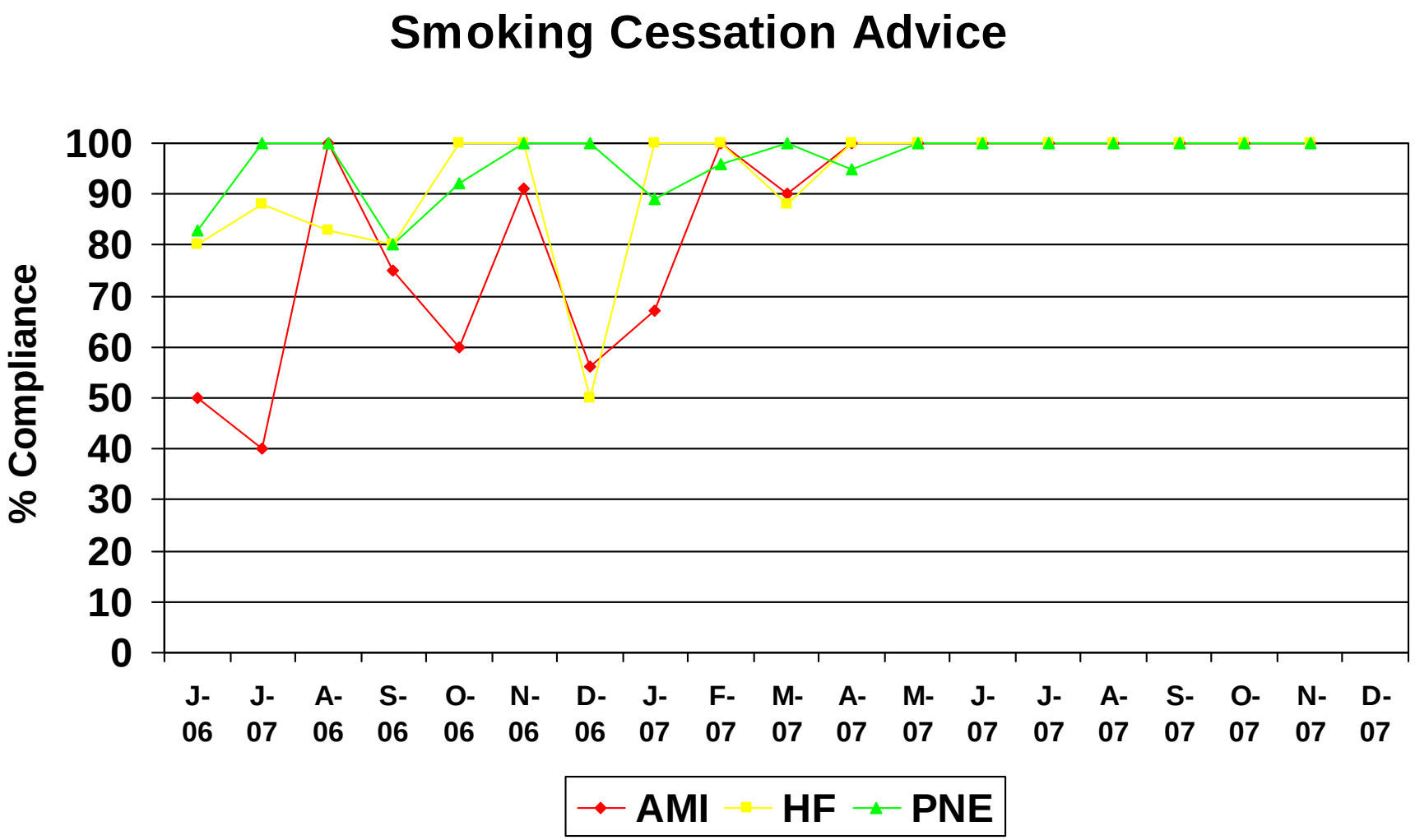
M.D. Signature _____ LABEL

Date / Time _____ DEA No. _____

Smoking Cessation Advice: Educate/Validate Competency

- Monthly Staff Announcement
- Removal of old Forms from stock

Smoking Cessation Advice: Measure Conformance



Antibiotic within 1 Hour of Incision: Focus/PDSA/Rapid Cycle Design

- Problem:
  - Antibiotic start time not consistently within 1 hour of incision
  - Anesthesia refused to take responsibility for administering the antibiotic
- Design:
  - Agreed on process where surgery nurse would administer antibiotic
  - Incorporated antibiotic timing check with the surgical pause
- Redesign:
  - Anesthesiologists agreed to administer preoperative antibiotic

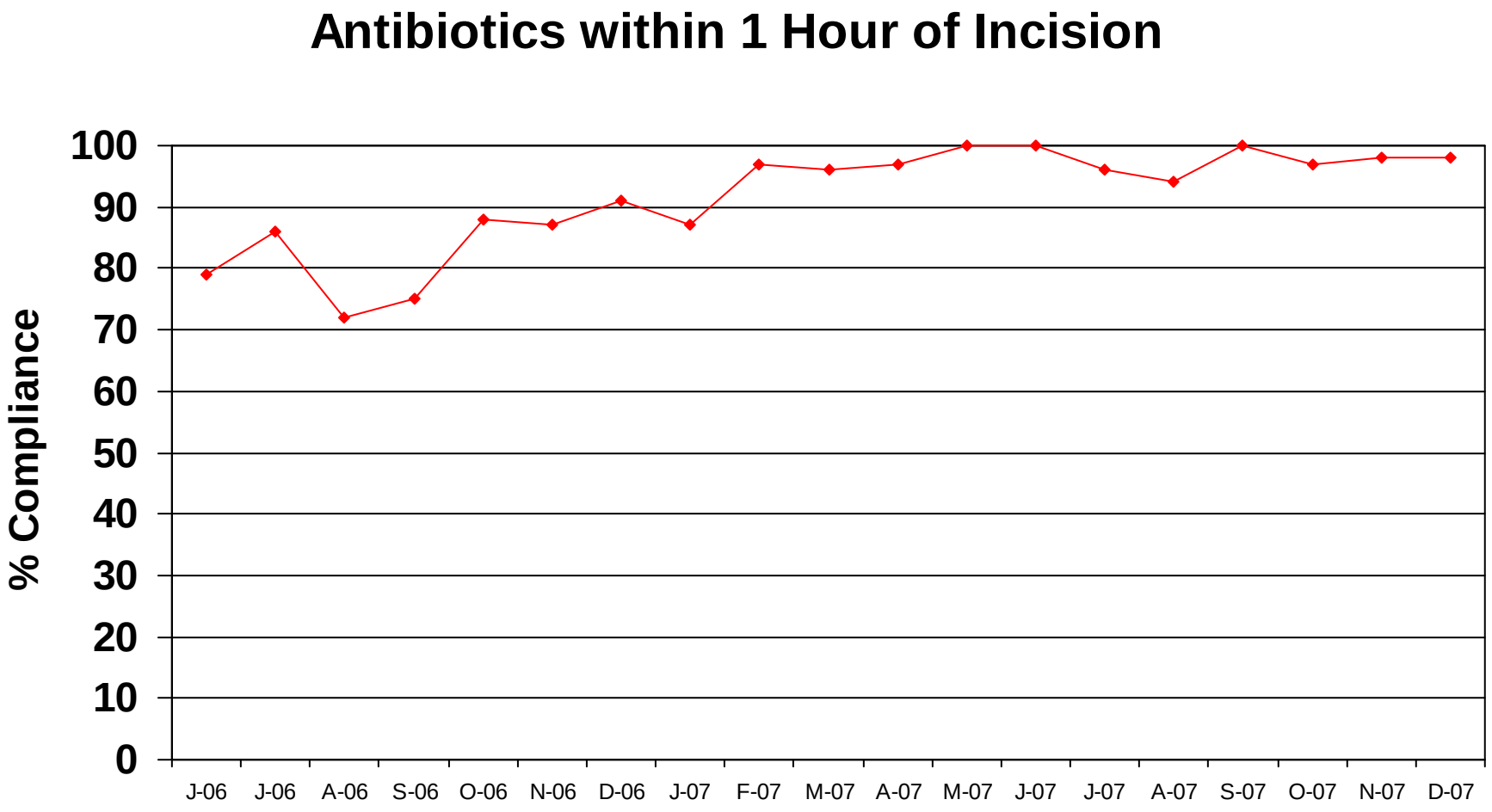
Antibiotic within 1 Hour of Incision: Educate

- Staff Meetings to clarify role of surgery nurse regarding antibiotic administration
- Staff meetings with OR nurses to clarify role for antibiotic check during the surgical pause
- Postings on bulletin board
- Series of educational presentations to physicians and staff
- Education to Anesthesiologists regarding revised design

Antibiotic within 1 Hour of Incision: Validate Competency

- Concurrent review of successes and failures
- 1:1 feedback to staff
- 1:1 feedback to anesthesiologists by anesthesia leaders

Antibiotic within 1 Hour of Incision: Measure Conformance



ABX time < 4 hrs Pneumonia: Focus/PDSA/Rapid Cycle Design

- Problem:
  - Most cases where timeframe exceeded due to delay in diagnosis and atypical presentation
  - Multiple factors responsible: triage process, ED MD didn't know when CXR done and available to be read

- Design:
  - Implemented process for CXR to be ordered with STAT wet read results to ED MD or ED Charge Nurse 5/07
  - Changed triage process 7/07 to reduce delays (adopted national triage process)
  - Real time positive x-ray reads
  - Algorithm for direct admissions

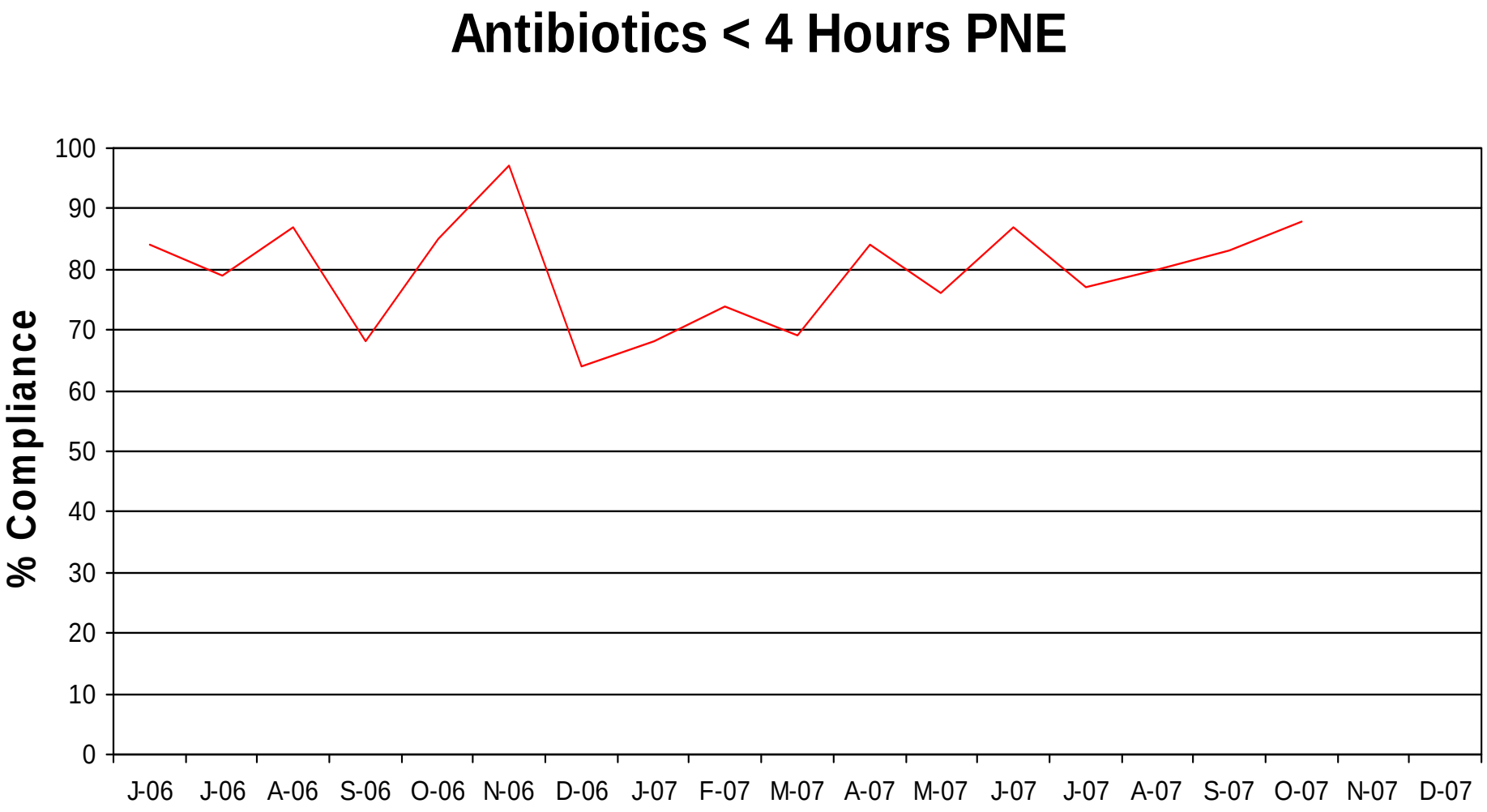
ABX time < 4 hrs Pneumonia: Educate

- ED Skills days in October with area of focus on pneumonia and AMI – mandatory for all staff in the ED
- Shift Report 7 times per day for a week
- Laminated posters
- Physician leaders provided training to providers
- Email to inpatient staff
- Staff meetings with inpatient staff

ABX time < 4 hrs Pneumonia: Validate Competency

- Concurrent review of successes and failures
- 1:1 feedback physician leader to physicians
- 1:1 feedback nursing leader to staff on both successes and failures
- Weekly team review
- Mandatory reply to inpatient email communication

ABX time < 4 hrs Pneumonia: Measure Conformance



Blood Cultures before ABX in ED for Pneumonia: Focus/PDSA/Rapid Cycle Design

- **Problem:**
  - Blood culture draw time documented after antibiotic administration time
  - Blood culture ordered after antibiotic ordered and administered or specimen labeling process not being followed
  - Many failures only minutes off

- **Design:**
  - Reminder built into Omnicell to direct nurse to check with ED MD if blood cultures not ordered before administering antibiotic 9/07
  - Epic (patient information system) Time = Consistent Clock
  - Red dot on armband to indicate culture drawn (in process)

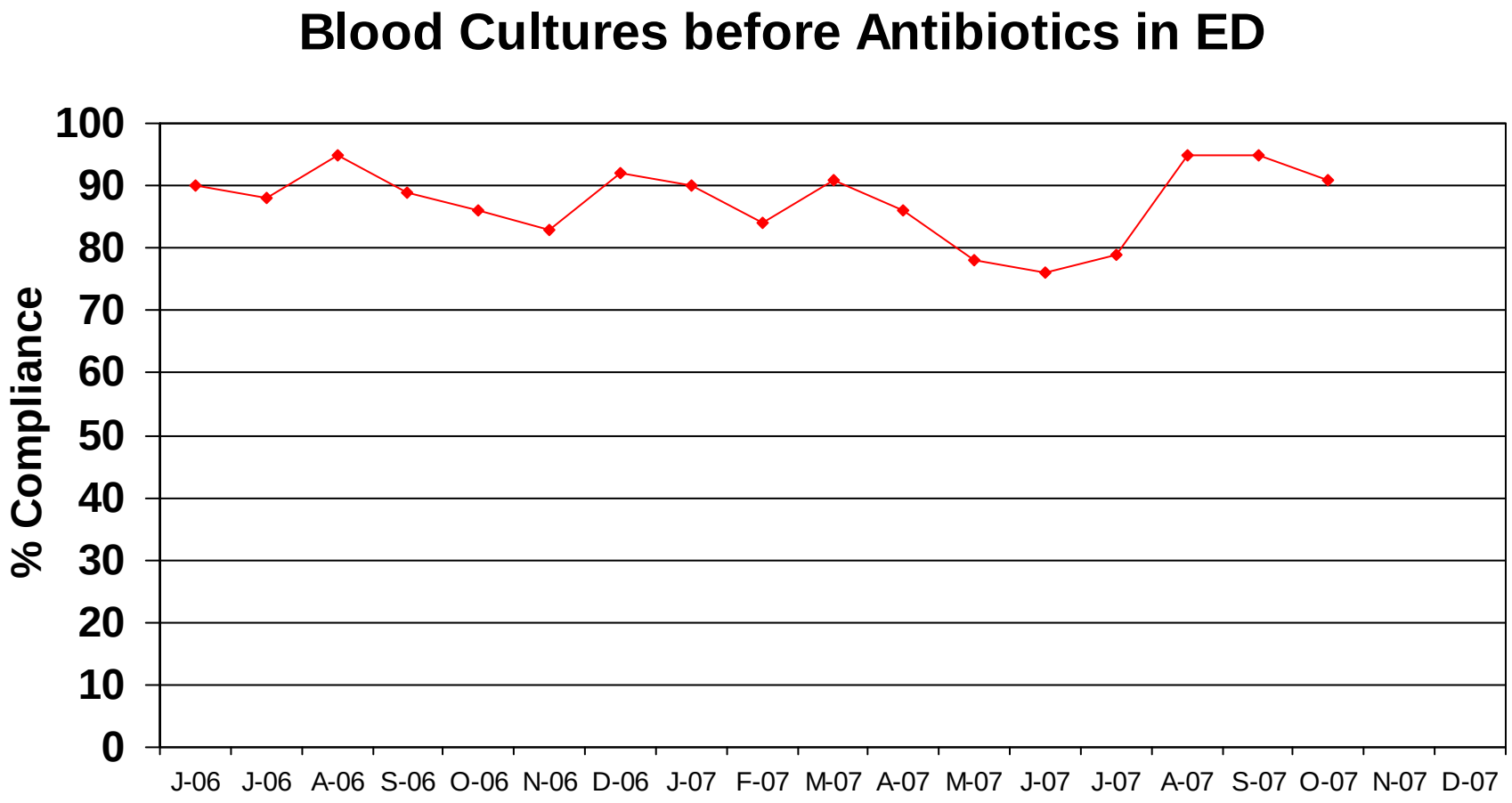
Blood Cultures before ABX in ED for Pneumonia: Educate

- ED Skills days in October with area of focus on pneumonia and AMI – mandatory for all staff in the ED
- Shift Report 7 times per day for a week
- Specific education for techs (in charge of labeling blood)
- Protocol of the week

Blood Cultures before ABX in ED for Pneumonia: Validate Competency

- Concurrent review of successes and failures
- 1:1 feedback physician leader to physicians
- 1:1 feedback nursing leader to staff on both successes and failures
- Weekly team review

Blood Cultures before ABX in ED for Pneumonia: Measure Conformance



Premier Pre-Conference Agenda
Advanced Strategies in Hospital Pay for Performance

- **8:30 AM – Welcome and Introductions**
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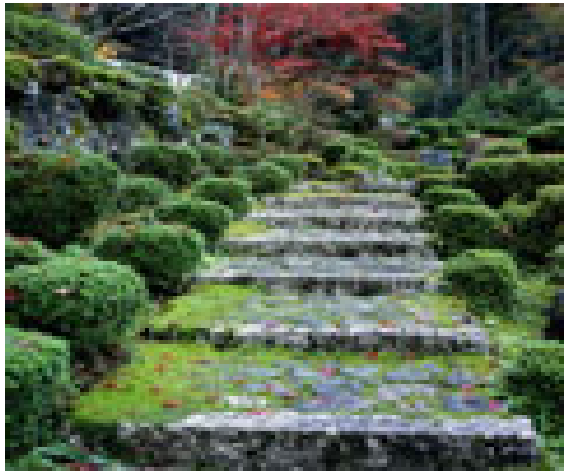
System-wide Approach to Clinical Improvements



Quality, Patient Safety and Perfect Care

Ginny Ripslinger RN,MBA
St. Joseph Health System
AVP Knowledge Management
February 2008

Objectives
System-wide Approach to Clinical Improvements

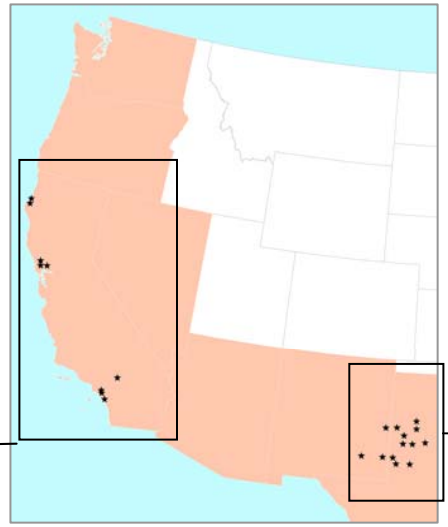
- **To understand the intent of ‘Perfect Care’ within St. Joseph Health System (SJHS) strategic goals**
- **To understand the components identified as critical success factors for attaining Perfect Care**
- **To understand the challenges facing SJHS**
- **To understand the priorities identified to assist with the journey to Perfect Care**

ST. JOSEPH HEALTH SYSTEM

SJHS serves ten distinct communities within three general regions—Northern California, Southern California and West Texas/New Mexico.

***Facilities**: Fourteen hospitals, three home health agencies and multiple physician groups, and a Health Plan.*

Total licensed beds: 3,607
Total discharges: 135,200
Patient days: 655,113
Total outpatient visits: 1,775,345



Saint Joseph Health System

- *Mission*
  - *To extend the Catholic healthcare ministry of the Sisters of St. Joseph of Orange, by continually improving the health and quality of life of people in the communities we serve.*
- Vision
  - *We bring people together to provide compassionate care, promote health improvement and create healthy communities.*
- Values
  - *The four core values of St. Joseph Health System -- Service, Excellence, Dignity and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.*

ST. JOSEPH HEALTH SYSTEM

St. Joseph Health System

- Strategic Priorities
  - Sacred Encounters
  - Perfect Care
  - Healthiest Communities

ST. JOSEPH
HEALTH SYSTEM

Background

- **Centers Medicare and Medicaid Services (CMS)**
  - Driving the shared vision
  - Business case
- **SJHS Quality Committee of the Board of Trustees**
- **Value-Based Purchasing Education**
  - Reading Materials
  - Presentation - Value-Based Purchasing
    - National Current State - Centers Medicare and Medicaid Services (CMS)
  - Future Meetings
    - Focus on Quality Committee Questions
    - SJHS Guidelines for Participating in Value-Based Purchasing/Pay for Performance Programs

ST. JOSEPH HEALTH SYSTEM

The Questions of Concern

Quality Committee

- Who will benefit from CMS' vision for quality improvement?
- How does CMS' plan to improve quality of care?
- Why is CMS leading Value-Based Purchasing?
- What is Value-Based Purchasing?
- Is Value-Based Purchasing changing practice?
- Is Value-Based Purchasing changing patient outcomes?
- Is SJHS prepared to meet the requirements for participating in Value-Based Purchasing?
- Other concerns to discuss/dialogue?

ST. JOSEPH HEALTH SYSTEM

VISION - Quality Improvement Roadmap

- SJHS alignment with CMS' vision:

  "the right care for every person every time"

  - Safe
  - Effective
  - Efficient
  - Patient-centered
  - Timely
  - Equitable
  - Spiritual (SJHS)

ST. JOSEPH HEALTH SYSTEM

Perfect Care

- Initial Metrics
  - Three year commitment - 2008 thru 2010
  - Inpatient Acute Care Focused
    - Medicare and Medicaid (CMS) 21 metrics
      - Heart Failure
      - Acute Myocardial Infarction
      - Community Acquired Pneumonia
      - Surgical Care Infection Prevention
    - Elimination of Ventilator-Associated Pneumonia
    - Elimination of Retained Foreign Bodies
    - Elimination of Wrong Site/Wrong Person Surgeries
    - Reduction of the Observed/Expected Ratio for Mortality

ST. JOSEPH HEALTH SYSTEM

WHY - CMS' VBP

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensive
  - To empower consumers to make value-based decisions about their health care
  - To encourage hospitals and clinicians to improve quality of care

ST. JOSEPH HEALTH SYSTEM

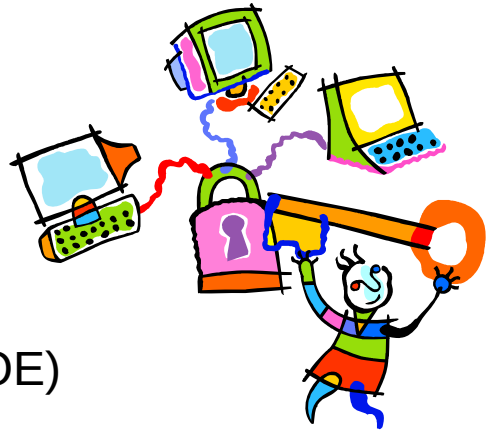
Challenges

- Creating shared vision
- Physician accessibility
- Physician partnerships – buy in and alignment
- Cost of Information Technology

ST. JOSEPH HEALTH SYSTEM

SJHS Response to the Challenges

- St. Joseph Way
  - Operational efficiency and effectiveness
    - Performance improvement processes (Toyota Lean Production System)
    - Using data to drive results
- Enterprise Perfect Care Applications
  - Benchmarking database
  - Incident reporting
  - Infection control
- Design for Perfect Care - Inpatient
  - Clinical Documentation
  - Computerized Physician Order Entry (CPOE)
  - PACS
- Physician Strategy
  - Information Technology Integration
- Data Repository



ST. JOSEPH HEALTH SYSTEM

Ministry Response to the Challenges

- Focused *leadership*
- *Alignment* of clinicians and employees
- *Accountability* to imbedding evidence-based practices and known best practices into work processes
- Ongoing *awareness of concurrent progress* throughout the ministry

ST. JOSEPH HEALTH SYSTEM

SJHS Opportunities

- Pay for performance and public report cards are here to stay
  - Sense of Urgency
    - Clinicians perform reliable care processes
    - Information Systems
      - Hardwiring tools and resources
      - Easy data/information retrieval
      - Easy end-user analysis for performance
- CMS' move to no payment for preventable in-hospital co-morbidities
- CMS' direction to pay incentive payments for performance
- Consumer-directed health plans require higher intensity of review for plan terms and performance

ST. JOSEPH HEALTH SYSTEM

Answers to the ‘Questions of Concern’

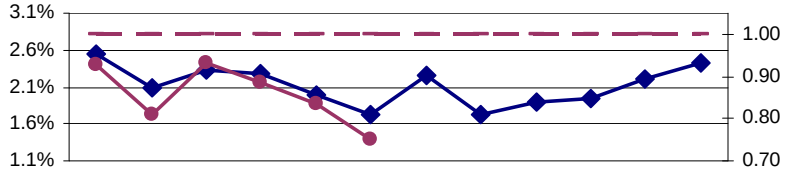
- Patients will benefit from CMS’ vision for quality improvement.
- CMS’ plan to improve quality of care is broad in scope and across the continuum of care.
- CMS is leading Value-Based Purchasing to pay for high quality care.
- Value-Based Purchasing is set to avoid costs for payers and result in better care.
- Value-Based Purchasing is changing practice for evidence based care in targeted care processes.
- Isolated examples that Value-Based Purchasing is changing patient outcomes.
- SJHS is setting the foundation to meet the requirements for participating in Value-Based Purchasing.

ST. JOSEPH HEALTH SYSTEM

SJHS Landscape Today

ST. JOSEPH HEALTH SYSTEM

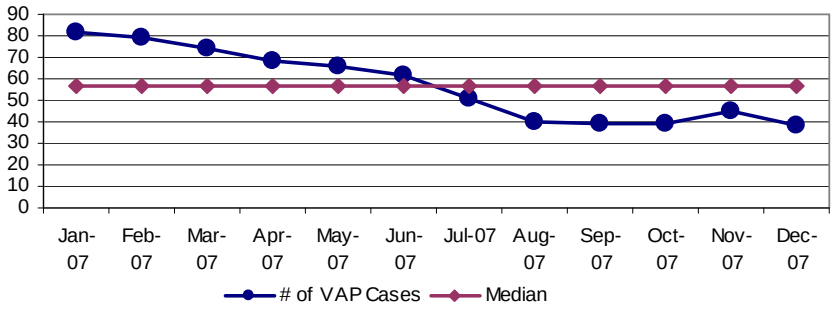
Acute Care Mortality Rate non-severity adjusted Monthly Rates



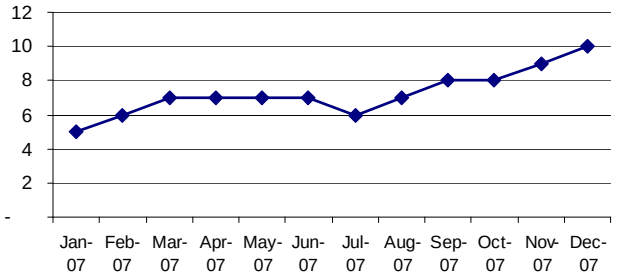
	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07
Mortality Rate	2.5%	2.1%	2.3%	2.3%	2.0%	1.7%	2.3%	1.7%	1.9%	1.9%	2.2%	2.4%
Mortality O/E Ratio	0.93	0.81	0.93	0.89	0.83	0.75						
Database Ave.	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

The Database Average is the severity adjusted average of the Premier Comparative Database

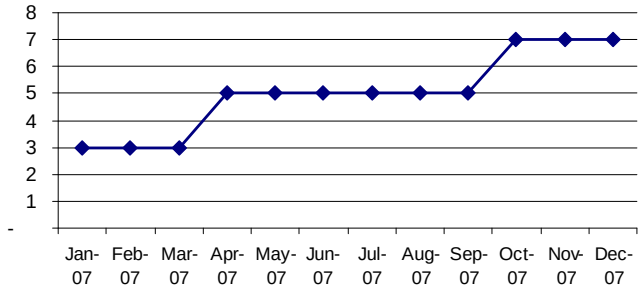
Total Number of VAP Cases Rolling 12 Months



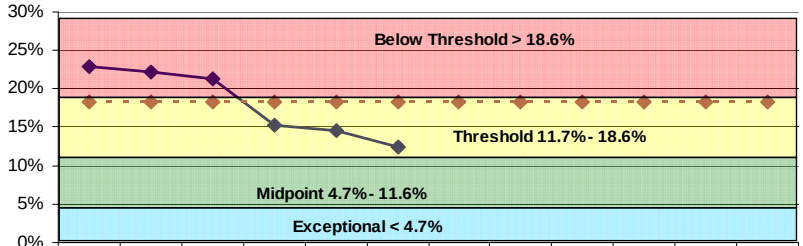
Total Number of Retained Foreign Bodies Rolling 12 Months



Total Number of Wrong Site Surgeries Rolling 12 Months



Patient Centered Perfect Care Monthly Rates



	JUL 2007	AUG 2007	SEP 2007	OCT 2007	NOV 2007	DEC 2007	JAN 2008	FEB 2008	MAR 2008	APR 2008	MAY 2008	JUN 2008
PC2	22.91%	22.23%	21.28%	15.26%	14.59%	12.39%						
Median	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%	18.27%
# of Patients	860	904	799	557	425	234						

Data source for the Patient Centered Perfect Care score is Premier and some manually collected data submitted by the ministries to the Health System office. All data July 2007 to present is preliminary. The goals for PC² are calculated as an improvement from the baseline failure rate (Q4 FY07). Threshold is a 20% improvement, Midpoint is a 50% improvement and Exceptional is a 80% improvement. The acute care non-severity adjusted Mortality Rate is calculated from the total number of acute care inpatient discharges divided by the total number of acute care all cause deaths submitted by the ministries to the Health System office. Acute care is defined as all inpatients except patient type skilled nursing, rehabilitation, psychiatric and chemical dependency. The data source for the Mortality O/E ratio is Premier. Retained Foreign Body and Wrong Site Surgery are collected by the ministries and reported to the Health System office. VAP data is collected by the ministries and reported to the Health System Office. Each data point on the graphs for VAP, Wrong Site Surgery and Retained Foreign Body show a rolling year to date value.

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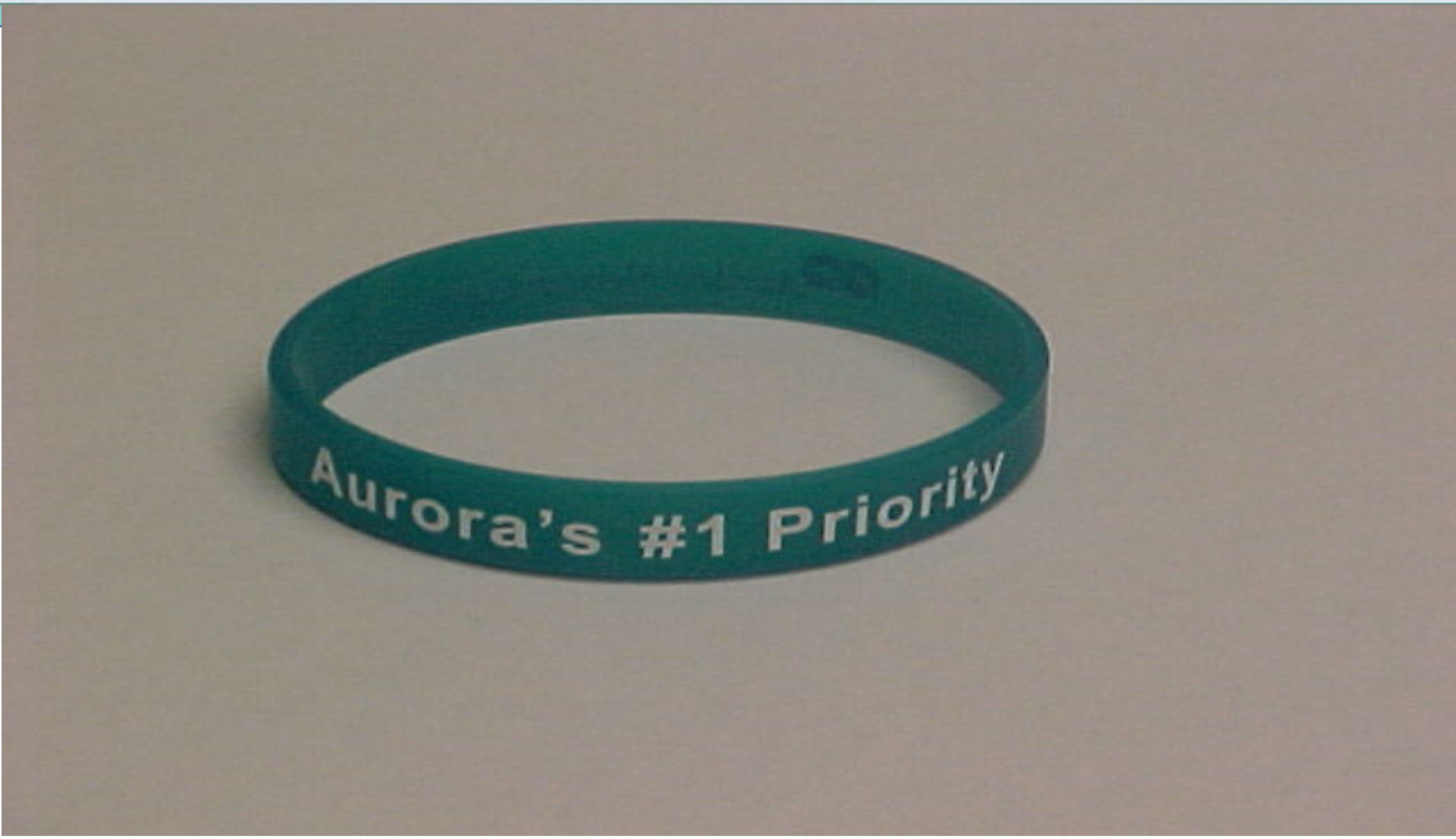
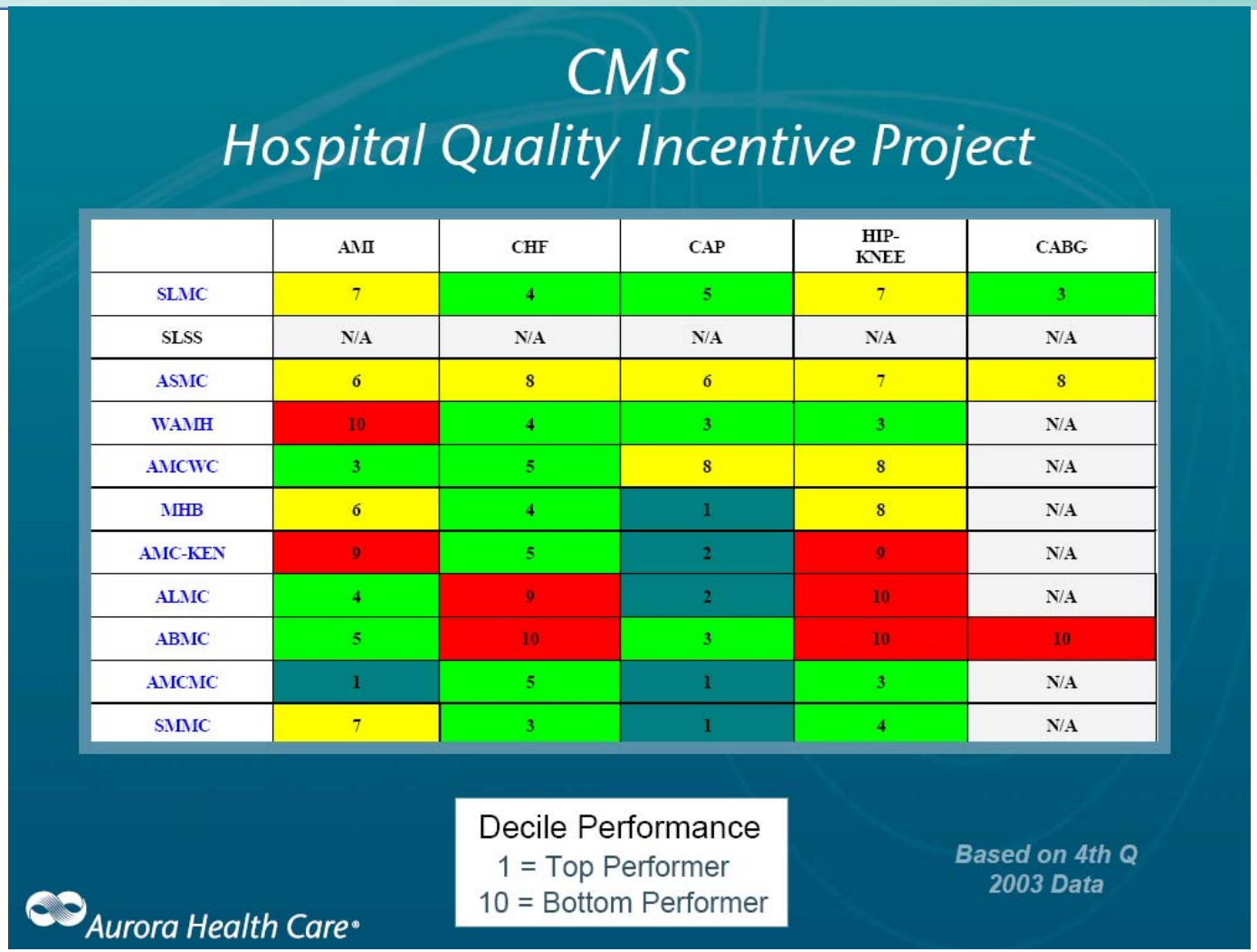
Unique Improvement Tools from an HQID Top Performer

Lori Knitt, Director of Medical Staff / Quality Services,
Aurora Sheboygan Memorial Hospital

Unique Improvement Tools



Unique Improvement Tools



	AMI	CHF	CAP	HIP-KNEE	CABG
SLMC	7	4	5	7	3
SLSS	N/A	N/A	N/A	N/A	N/A
ASMC	6	8	6	7	8
WAMH	10	4	3	3	N/A
AMCWC	3	5	8	8	N/A
MHB	6	4	1	8	N/A
AMC-KEN	9	5	2	9	N/A
ALMC	4	9	2	10	N/A
ABMC	5	10	3	10	10
AMCMC	1	5	1	3	N/A
SMMC	7	3	1	4	N/A

Unique Improvement Tools

CONFIDENTIAL
PRELIMINARY RESULTS

AURORA SHEBOYGAN MEMORIAL MEDICAL CENTER
Hospital Quality Incentive Demonstration Project
Reporting for the period: October 2004 - June 2005

PREMIER

The Hospital Quality Incentive Demonstration Project report displays the individual numerator, denominator, calculated measure rate, and decile for each measure. The composite process score, survival index (if applicable), and the Composite Score are displayed for each area. The HQI Decile Threshold information displays the lowest score for each decile. This report is for your use and will not be made public by Premier.

Area/Measure	Facility Numerator	Facility Denominator	Facility Rate/Index	CQS Decile	HQI Decile Threshold Score 1st (Top)	2nd	3rd	4th	5th (Median)	YR 1 Baseline 8th	YR 1 Baseline Bottom
AMI											
Aspirin at arrival	41	44	93.18%		100.00%	98.35%	97.41%	96.76%	95.83%	90.76%	88.19%
Aspirin prescribed at discharge	10	11	90.91%		99.60%	99.07%	98.34%	97.20%	96.21%	86.84%	80.77%
ACEI or ARB for LVSD	1	1	100.00%		100.00%	96.00%	91.11%	88.00%	85.00%	66.67%	60.00%
Adult smoking cessation advice/counseling	2	2	100.00%		100.00%	100.00%	99.51%	97.34%	95.42%	61.11%	46.15%
Beta blocker prescribed at discharge	11	13	84.62%		100.00%	98.78%	97.59%	96.67%	95.56%	82.76%	76.19%
Beta blocker at arrival	33	35	94.29%		100.00%	98.10%	96.67%	94.74%	93.75%	81.82%	75.97%
Thrombolytic agent received within 30 minutes of hospital arrival	1	3	33.33%		75.00%	62.50%	50.00%	33.33%	22.22%	0.00%	0.00%
Composite Process Component (1)	99	109	90.83%		97.32%	96.02%	94.90%	93.89%	93.15%	84.10%	80.14%
Survival Index (2)	66.67%	82.98%	80.35%								
Composite Quality Score (3)			89.66%	8	97.70%	96.44%	95.83%	94.81%	93.70%	85.18%	81.42%
Heart Failure											
Discharge instructions	78	87	89.66%		92.59%	86.36%	80.68%	72.55%	66.29%	22.54%	10.71%
LVF assessment	103	113	91.15%		98.63%	97.28%	95.54%	93.89%	92.46%	79.26%	71.50%
ACEI or ARB for LVSD	27	28	96.43%		98.17%	93.33%	90.82%	87.38%	83.62%	66.13%	58.33%
Adult smoking cessation advice/counseling	15	15	100.00%		100.00%	100.00%	96.49%	94.37%	91.30%	46.91%	38.04%
Composite Quality Score (7)	223	243	91.77%	2	93.66%	90.37%	86.93%	84.03%	81.31%	57.89%	52.82%

Unique Improvement Tools

Unique Improvement Tools

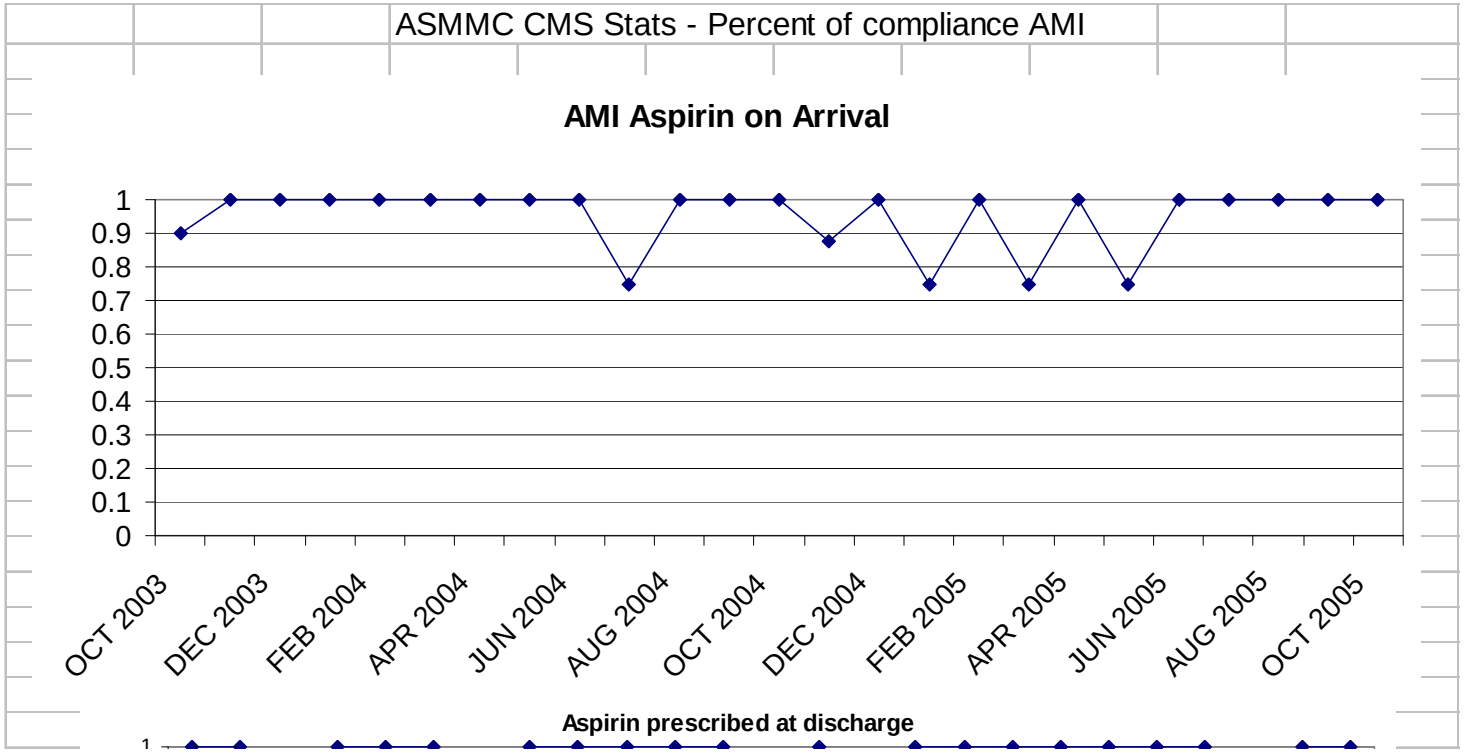
Unique Improvement Tools

Unique Improvement Tools

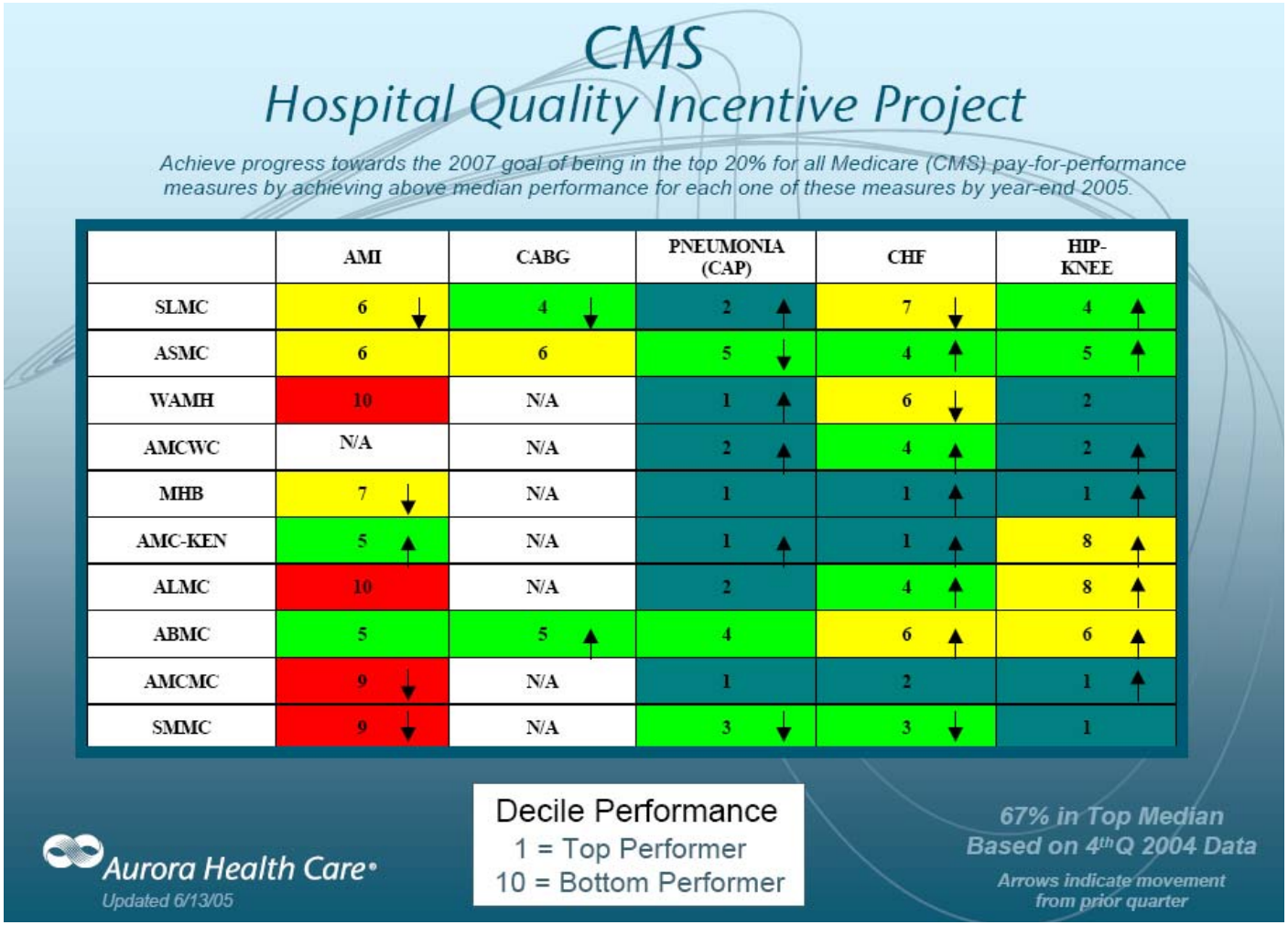
Unique Improvement Tools

Clinical Focus Group	Measures	Month	Population	Missing/Invalid Population	Numerator	Missing/Invalid Numerator
Acute Myocardial Infarction	Aspirin at arrival	APR 2005	7	0	4	0
		MAY 2005	6	0	3	0
		JUN 2005	5	0	3	0
	Aspirin Prescribed at discharge	APR 2005	7	0	1	0
		MAY 2005	6	0	1	0
		JUN 2005	5	0	1	0
	ACEI or ARB for LVSD	APR 2005	7	0	0	0
		MAY 2005	6	0	0	0
		JUN 2005	5	0	0	0
	Adult smoking cessation advice / counseling	APR 2005	7	0	1	0
		MAY 2005	6	0	0	0
		JUN 2005	5	0	0	0
	Beta Blocker prescribed at discharge	APR 2005	7	0	0	0
		MAY 2005	6	0	1	0
		JUN 2005	5	0	1	0
	Beta Blocker at arrival	APR 2005	7	0	2	0
		MAY 2005	6	0	3	0
		JUN 2005	5	0	3	0
	Thrombolytic agent received within 30 minutes of hospital arrival	APR 2005	7	0	0	0
		MAY 2005	6	0	1	0
		JUN 2005	5	0	0	0
	PCI received within 120 minutes of hospital arrival	APR 2005	7	0	0	0
		MAY 2005	6	0	0	0
		JUN 2005	5	0	0	0
	Inpatient mortality	APR 2005	7	0	0	0
		MAY 2005	6	0	0	0
		JUN 2005	5	0	0	0

Unique Improvement Tools



Unique Improvement Tools



	AMI	CABG	PNEUMONIA (CAP)	CHF	HIP-KNEE
SLMC	6 ↓	4 ↓	2 ↑	7 ↓	4 ↑
ASMC	6	6	5 ↓	4 ↑	5 ↑
WAMH	10	N/A	1 ↑	6 ↓	2
AMCWC	N/A	N/A	2 ↑	4 ↑	2 ↑
MHB	7 ↓	N/A	1	1 ↑	1 ↑
AMC-KEN	5 ↑	N/A	1 ↑	1 ↑	8 ↑
ALMC	10	N/A	2	4 ↑	8 ↑
ABMC	5	5 ↑	4	6 ↑	6 ↑
AMCMC	9 ↓	N/A	1	2	1 ↑
SMMC	9 ↓	N/A	3 ↓	3 ↓	1

Unique Improvement Tools

CMS HQID Carnival

Unique Improvement Tools

CMS
Hospital Quality Incentive Project

Achieve progress towards the 2007 goal of being in the top 20% for all Medicare (CMS) pay-for-performance measures by achieving above median performance for each one of these measures by year-end 2005.

	AMI		CABG		PNEUMONIA (CAP)		CHF		HIP-KNEE	
	4Q 2004	1Q 2005	4Q 2004	1Q 2005	4Q 2004	1Q 2005	4Q 2004	1Q 2005	4Q 2004	1Q 2005
ASLMC	6	7	4	4	2	3	7	7	4	5
ASMC	6	3	6	1	5	4	4	4	5	2
WAMH	10	9	N/A	N/A	1	1	6	4	2	1
AMCWC	N/A	N/A	N/A	N/A	2	4	4	4	2	2
MHB	7	1	N/A	N/A	1	1	1	1	1	2
AMC-KEN	5	7	N/A	N/A	1	1	1	1	8	4
ALMC	10	9	N/A	N/A	2	1	4	3	8	7
ABMC	5	8	5	7	4	4	6	3	6	6
AMCMC	9	5	N/A	N/A	1	1	2	1	1	1
ASMMC	9	9	N/A	N/A	3	1	3	2	1	2

Decile Performance
1 = Top Performer
10 = Bottom Performer

% in Top Median to be determined Based on 4th Q 2004 and 1st Q 2005 Data

Aurora Health Care

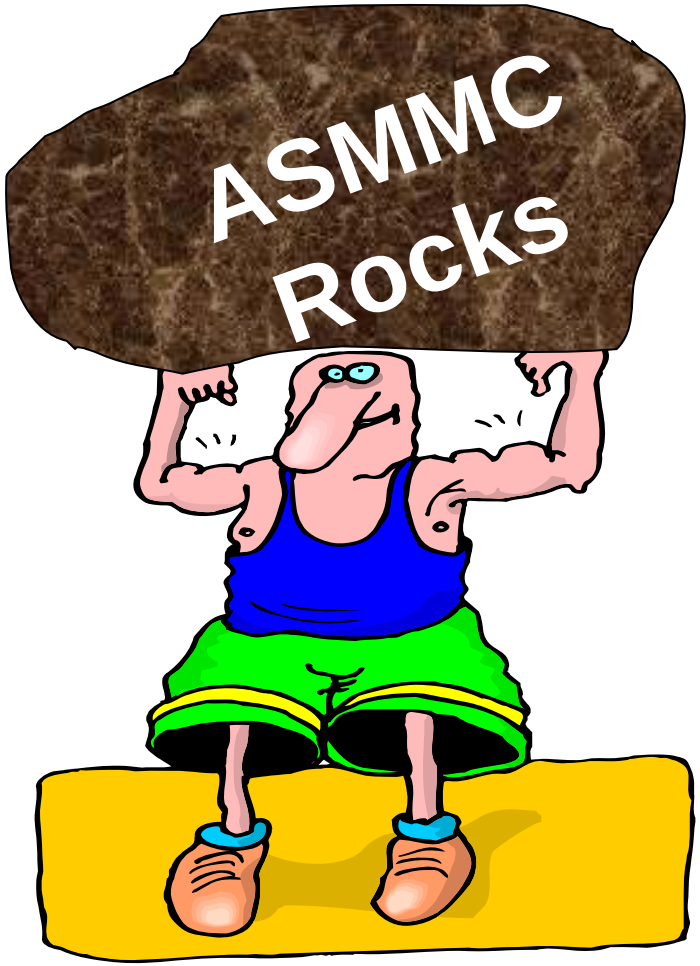
Updated 10/10/05

Unique Improvement Tools

Key strategies:

- Increase utilization of Standard Order sets
- Education of metrics to physicians and staff
- Rapid feedback to involved practitioners
- Reward success

Unique Improvement Tools



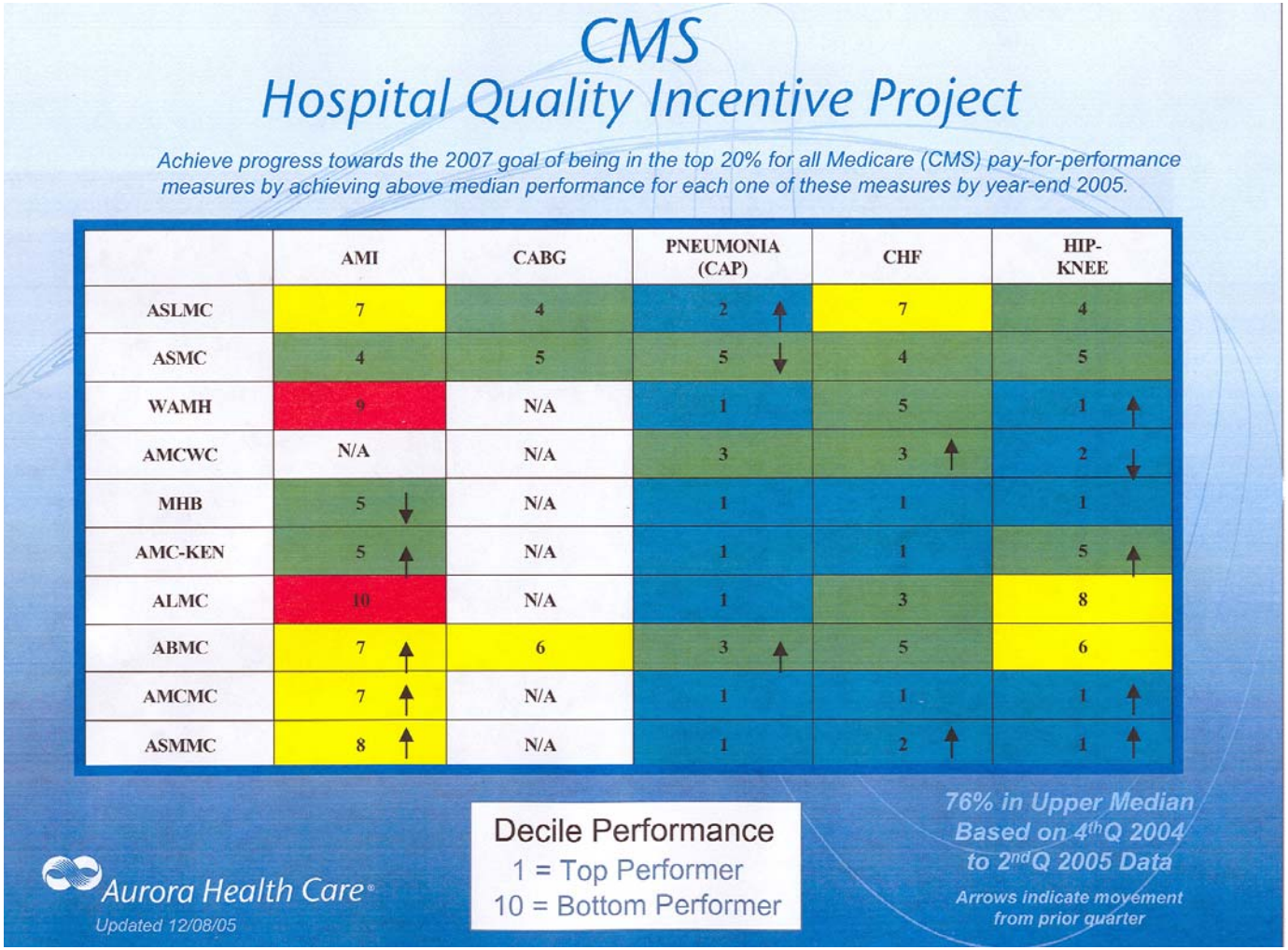
Unique Improvement Tools

Unique Improvement Tools

Reward success

- **Celebration of recognition as top performer, by System, industry etc.**
- **“You Rock” campaign – one rock will be given to each nursing unit for each patient that met all measures. Rocks will be placed in cylinder; when predetermined level is reached unit is rewarded with pizza, ice cream etc.**

Unique Improvement Tools



CMS
Hospital Quality Incentive Project

Achieve progress towards the 2007 goal of being in the top 20% for all Medicare (CMS) pay-for-performance measures by achieving above median performance for each one of these measures by year-end 2005.

	AMI	CABG	PNEUMONIA (CAP)	CHF	HIP-KNEE
ASLMC	7	4	2 ↑	7	4
ASMC	4	5	5 ↓	4	5
WAMH	9	N/A	1	5	1 ↑
AMCWC	N/A	N/A	3	3 ↑	2 ↓
MHB	5 ↓	N/A	1	1	1
AMC-KEN	5 ↑	N/A	1	1	5 ↑
ALMC	10	N/A	1	3	8
ABMC	7 ↑	6	3 ↑	5	6
AMCMC	7 ↑	N/A	1	1	1 ↑
ASMMC	8 ↑	N/A	1	2 ↑	1 ↑

Aurora Health Care®

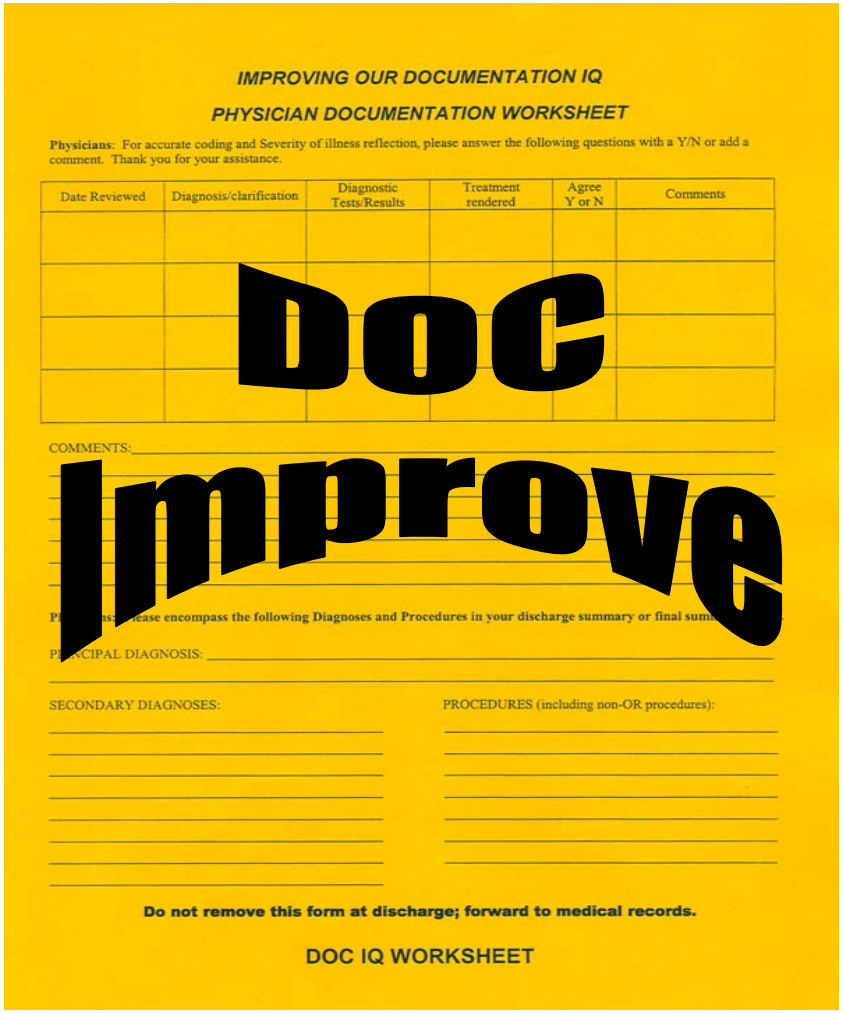
Updated 12/08/05

Decile Performance
1 = Top Performer
10 = Bottom Performer

76% in Upper Median Based on 4th Q 2004 to 2nd Q 2005 Data

Arrows indicate movement from prior quarter

Unique Improvement Tools



IMPROVING OUR DOCUMENTATION IQ

PHYSICIAN DOCUMENTATION WORKSHEET

Physicians: For accurate coding and Severity of illness reflection, please answer the following questions with a Y/N or add a comment. Thank you for your assistance.

Date Reviewed	Diagnosis/clarification	Diagnostic Tests/Results	Treatment rendered	Agree Y or N	Comments

Doc Improve

COMMENTS:

Please encompass the following Diagnoses and Procedures in your discharge summary or final sum

PRINCIPAL DIAGNOSIS:

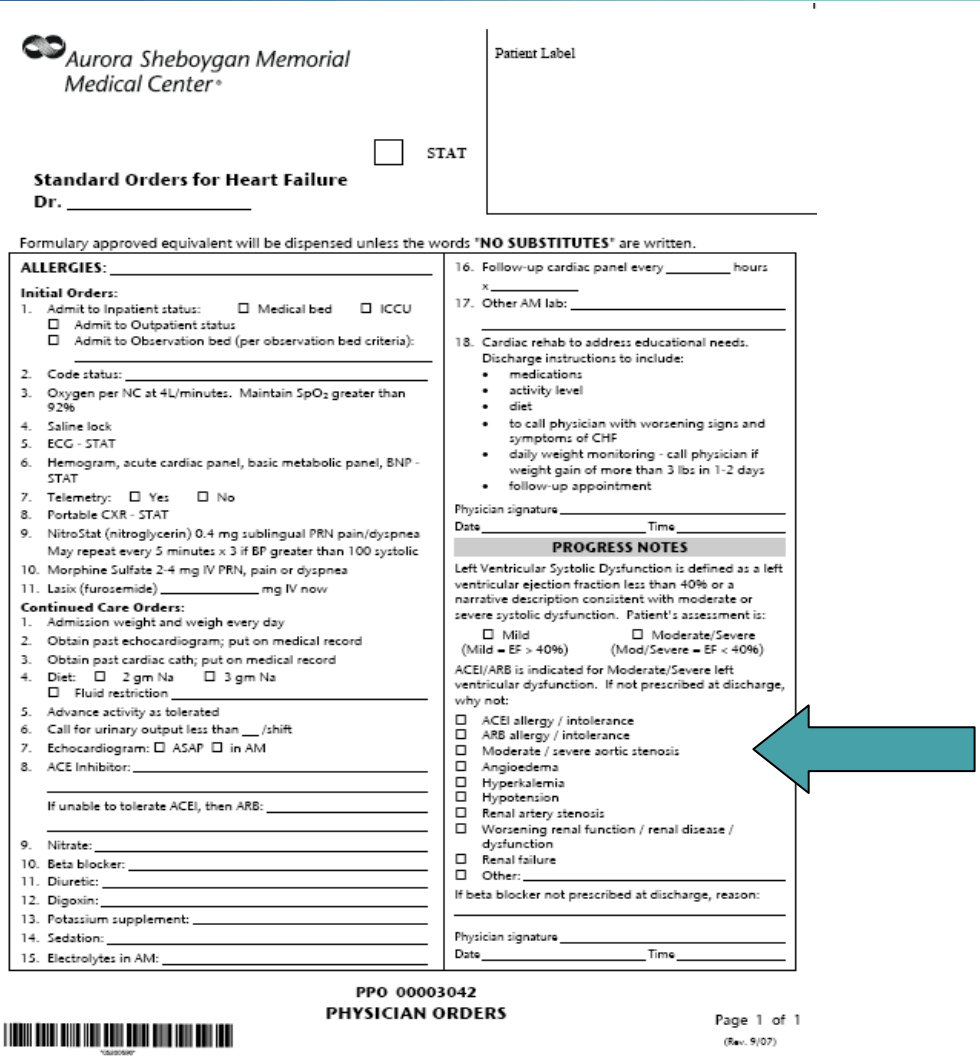
SECONDARY DIAGNOSES:

PROCEDURES (including non-OR procedures):

Do not remove this form at discharge; forward to medical records.

DOC IQ WORKSHEET

Unique Improvement Tools



Aurora Sheboygan Memorial Medical Center

Patient Label

☐ STAT

Standard Orders for Heart Failure
Dr. _____

Formulary approved equivalent will be dispensed unless the words "**NO SUBSTITUTES**" are written.

ALLERGIES: _____

Initial Orders:

1. Admit to Inpatient status: ☐ Medical bed ☐ ICCU
   ☐ Admit to Outpatient status
   ☐ Admit to Observation bed (per observation bed criteria):
   _____
2. Code status: _____
3. Oxygen per NC at 4L/minutes. Maintain SpO_2 greater than 92%
4. Saline lock
5. ECG - STAT
6. Hemogram, acute cardiac panel, basic metabolic panel, BNP - STAT
7. Telemetry: ☐ Yes ☐ No
8. Portable CXR - STAT
9. NitroStat (nitroglycerin) 0.4 mg sublingual PRN pain/dyspnea
   May repeat every 5 minutes x 3 if BP greater than 100 systolic
10. Morphine Sulfate 2-4 mg IV PRN, pain or dyspnea
11. Lasix (furosemide) _____ mg IV now

Continued Care Orders:

1. Admission weight and weigh every day
2. Obtain past echocardiogram; put on medical record
3. Obtain past cardiac cath; put on medical record
4. Diet: ☐ 2 gm Na ☐ 3 gm Na
   ☐ Fluid restriction _____
5. Advance activity as tolerated
6. Call for urinary output less than ___ /shift
7. Echocardiogram: ☐ ASAP ☐ in AM
8. ACE Inhibitor: _____
   _____
   If unable to tolerate ACEI, then ARB: _____
   _____
9. Nitrate: _____
10. Beta blocker: _____
11. Diuretic: _____
12. Digoxin: _____
13. Potassium supplement: _____
14. Sedation: _____
15. Electrolytes in AM: _____
16. Follow-up cardiac panel every _____ hours x _____
17. Other AM lab: _____
    _____
18. Cardiac rehab to address educational needs.
    Discharge instructions to include:
    - medications
    - activity level
    - diet
    - to call physician with worsening signs and symptoms of CHF
    - daily weight monitoring - call physician if weight gain of more than 3 lbs in 1-2 days
    - follow-up appointment

Physician signature _____
Date _____ Time _____

PROGRESS NOTES

Left Ventricular Systolic Dysfunction is defined as a left ventricular ejection fraction less than 40% or a narrative description consistent with moderate or severe systolic dysfunction. Patient's assessment is:

☐ Mild (Mild = EF > 40%) ☐ Moderate/Severe (Mod/Severe = EF < 40%)

ACEI/ARB is indicated for Moderate/Severe left ventricular dysfunction. If not prescribed at discharge, why not:

- ☐ ACEI allergy / intolerance
- ☐ ARB allergy / intolerance
- ☐ Moderate / severe aortic stenosis
- ☐ Angioedema
- ☐ Hyperkalemia
- ☐ Hypotension
- ☐ Renal artery stenosis
- ☐ Worsening renal function / renal disease / dysfunction
- ☐ Renal failure
- ☐ Other: _____

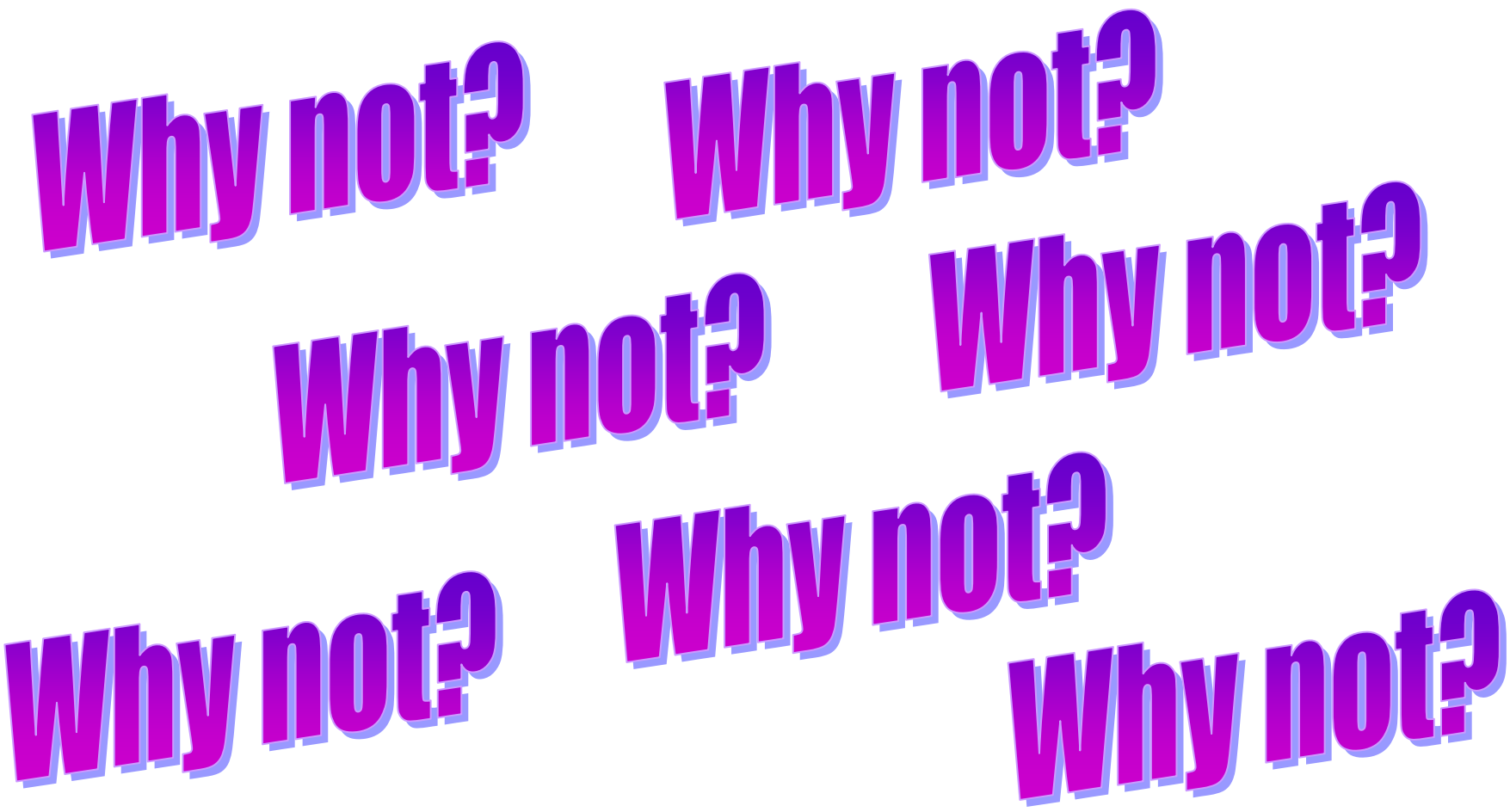
If beta blocker not prescribed at discharge, reason:
_____

Physician signature _____
Date _____ Time _____

PPO 00003042
PHYSICIAN ORDERS

Page 1 of 1
(Rev. 9/07)

Unique Improvement Tools



Unique Improvement Tools

Aurora Sheboygan Memorial Medical Center — May/June 2005

MEDICAL STAFF NEWS

A number of measures in the CMS Hospital Quality Incentive Project Study require documentation of why you did not order a particular medication e.g. ASA for AMI; β-blockers for AMI, ACEI for CHF etc. The pre-printed order sets associated with these measures provide an easy mechanism to document these clinical reasons.

In order for our quality of care to be accurately measured, we need this documentation to be completed!

The "**Why Not**" campaign posters, located in the ASMMC Physician's lounge and ICCU dictation area, will highlight a specific measure or two each week. Please review this information. Please contact me if you have any questions.

Example #1 *5-18-05*

*AMI **arrival** measure*

***Aspirin** is prescribed for the patient upon hospital arrival **or** the medical record reflects any of the allowed reasons for not prescribing:*

- *active bleeding upon arrival*
- *aspirin allergy*
- *warfarin / coumadin as pre-arrival medication*
- *specific reason that you write: _____* *(this reason has to explicitly explain why ASA was not ordered)*

Unique Improvement Tools

HQI Attending Physician Summary Report

Real-Time Quality Measures Report

Medicare Provider: 520035 AURORA SHEBOYGAN MEM MED CTR — 8/25/2005 1:38 PM

Attending Physician: SCHROEDER, GEORGE - SHEBOYGAN MEMORIAL MEDICAL CTR

Clinical Focus Group	Measures	Month	Medicare Provider CFG Population	CFG Sample	CFG Cases	Missing/Invalid Population
Congestive Heart Failure	Discharge instructions	Mar-05	19	19	1	0
	LVF assessment	Mar-05	19	19	1	0
	Adult smoking cessation advice/counseling	Mar-05	19	19	1	0
	ACEI or ARB for LVSD	Mar-05	19	19	1	0
Pneumonia	Oxygenation assessment	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Pneumococcal vaccination	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Blood culture before first antibiotic	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Adult smoking cessation advice / counseling	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Initial antibiotic received within 4 hours of hospital arrival	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Initial antibiotic selection for CAP in immunocompetent - ICU patient	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Initial antibiotic selection for CAP immunocompetent - Non ICU patient	Jan-05	26	26	1	0
		Mar-05	41	41	2	0
	Influenza vaccination	Jan-05	26	26	1	0
		Mar-05	41	41	2	0

Unique Improvement Tools

Unique Improvement Tools

Heart Failure Physician Feedback

Measure Name	*Quarter*	*DC Date*	*DC DOW*	*ED admit?*	*Age*	*Reason for Failure*
ACEI or ARB for LVSD						
	Q1 2005	3/11/2005	Friday		95	Physician Documentation
	Q1 2007	2/ 3/2007			74	Physician Documentation
Discharge instructions						
	Q1 2005	3/10/2005	Thursday		77	Nursing Documentation
	Q1 2005	2/ 2/2005	Wednesday			Nursing Documentation
	Q1 2006	3/16/2006	Thursday		77	Nursing Documentation
	Q1 2006	1/ 3/2006	Tuesday		92	Diagnosis confusion/delay
	Q1 2007	4/19/2007			70	Multiple process issues
	Q1 2007	5/18/2007			36	Multiple process issues
	Q2 2005	4/18/2005	Friday		83	Nursing Documentation
	Q2 2005	4/24/2005	Sunday		61	Nursing Documentation
	Q2 2005	5/15/2005	Sunday?		77	Nursing Documentation
	Q2 2006	6/17/2006	Saturday		81	Nursing Documentation

Unique Improvement Tools

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Unique Improvement Tools

Aurora Health Care®
Aurora Sheboygan Memorial Medical Center

January 20, 2005

Dear Dr. M,

Data was recently abstracted from your patient's medical record to be used in our CMS, JCAHO and Care Management data collections. Below is a summary of the data abstracted that did not meet the standard(s).

Please note that use of the pre-printed order set **and** your documentation is key to our success. For certain measures it is necessary for you to document "why not..." in order to meet the criteria. The Progress Note portion of the Cardiac Care and CHF Pre-printed order sets allow for documentation of the required measures.
Please contact me if you have any questions or need additional information.
Thank you for your assistance in our ongoing efforts to improve care quality at ASMMC!

Lori Knitt, RN, BSN
Manager, Medical Staff/Quality Services

Case Summary - AMI Measure not met:

Of the 1 patient that did not receive ASA within 24 hours before or after arrival, the following was noted:
MR #168905: XXNAMEXX, this 88-year-old female was brought to the SMMC ED at 2033 on 7/13/2004 by ambulance with c/o chest pain. Dr. R is the ED physician on duty. ED RNs include Kim F, RN and K. D., NE. The patient's primary physician, Dr. M was contacted by ED staff at 2050 and arrived in the ED at 2105. Cardiac enzymes consistent with AMI, but no medications/ treatment given in the ED other than an IV started. Chest pain worksheet was initiated but no medications ordered. Admission orders and H&P done by Dr. M, then Dr. B assumed care later the next day, 7/14. ASA prescribed by Dr. B on 7/15 p.m., approximately 42 hours after admission. ASA was continued/prescribed upon discharge.

Unique Improvement Tools

ACC/AHA PRACTICE GUIDELINES—FULL TEXT

ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure)

Developed in Collaboration With the American College of Chest Physicians and the International Society for Heart and Lung Transplantation

Endorsed by the Heart Rhythm Society

Insert good news / bad news slide here – or just delete

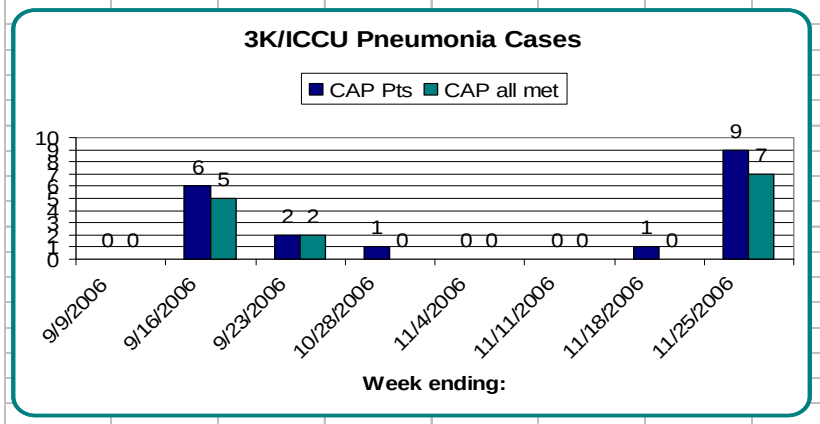
Unique Improvement Tools

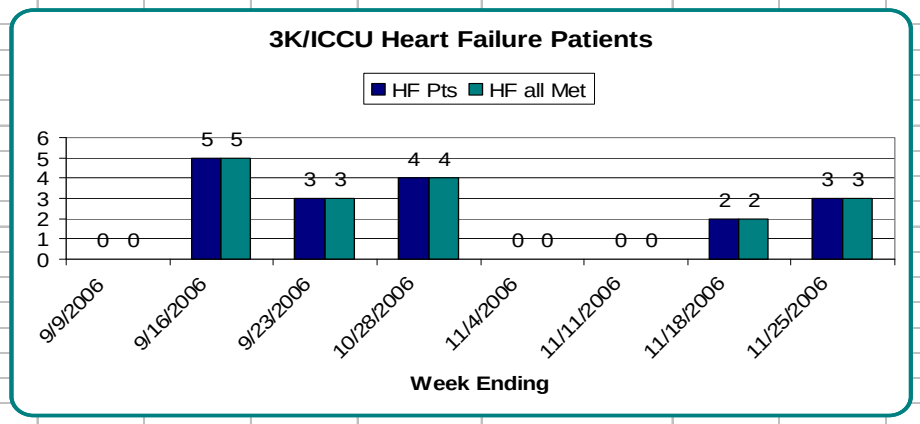
Concurrent Review

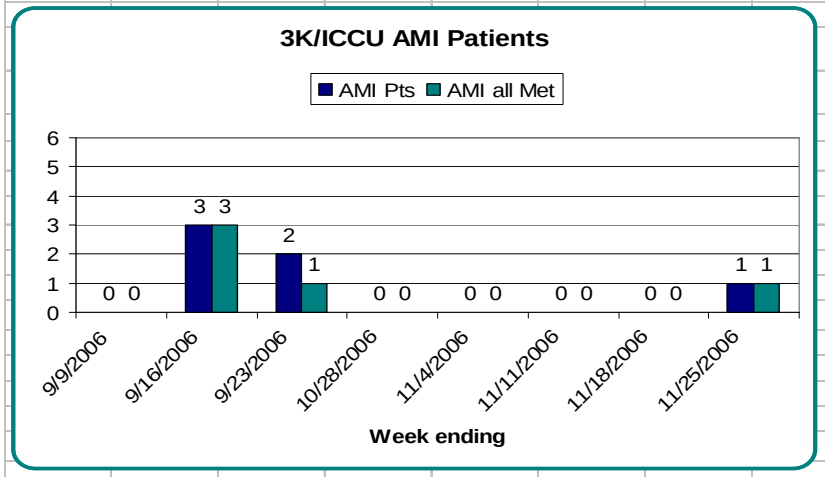
Unique Improvement Tools

3K/ICCU CMS Patients

All patients reviewed compared to
the number of patients receving 100% best practice care (met all measures)
based on concurrent chart review







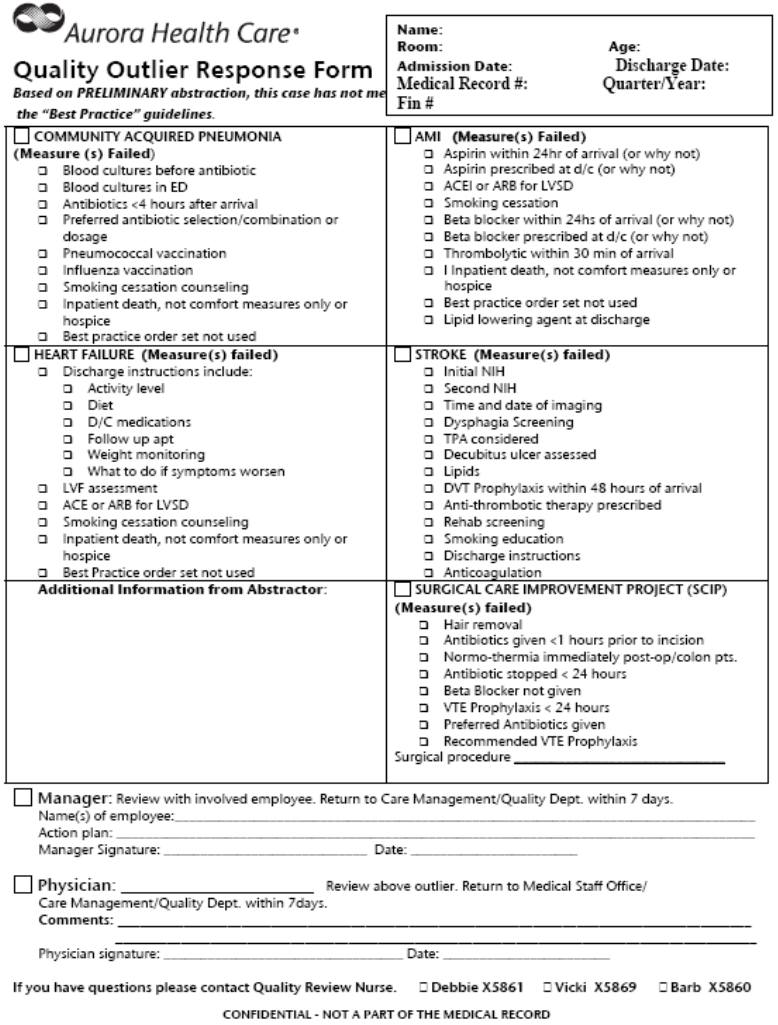
Who met the measures? Who didn't? Were these your patients?

For the periods ending: ***11/25/2006***

Pneumonia	**Met**	**Not Met**
Gina Hotrod	Richard Miller	Deborah Miller - Flu vaccine not given
Neil Armstrong	Mary Star	Carolyn Conner - Flu vaccine not given
David Miller	Elfrieda Panos	Elizabeth Dole - Abx >4 hrs
Donald Duck		
Heart Failure	**Met**	**Not Met**
Hulda Zulda	Claude VanDamm	All patients met measures
Donald Diller	Bonnie Boop	
	John Kampman	
AMI	**Met**	**Not Met**
	Kim Kennedy	All patients met measures

Note: not all cases will be in final CMS population

Unique Improvement Tools



Aurora Health Care

Quality Outlier Response Form

Based on PRELIMINARY abstraction, this case has not me
the "Best Practice" guidelines.

Name:
Room: **Age:**
Admission Date: **Discharge Date:**
Medical Record #: **Quarter/Year:**
Fin #

☐ **COMMUNITY ACQUIRED PNEUMONIA (Measure (s) Failed)**
- ❑ Blood cultures before antibiotic
- ❑ Blood cultures in ED
- ❑ Antibiotics <4 hours after arrival
- ❑ Preferred antibiotic selection/combination or dosage
- ❑ Pneumococcal vaccination
- ❑ Influenza vaccination
- ❑ Smoking cessation counseling
- ❑ Inpatient death, not comfort measures only or hospice
- ❑ Best practice order set not used

☐ **AMI (Measure(s) Failed)**
- ❑ Aspirin within 24hr of arrival (or why not)
- ❑ Aspirin prescribed at d/c (or why not)
- ❑ ACEI or ARB for LVSD
- ❑ Smoking cessation
- ❑ Beta blocker within 24hs of arrival (or why not)
- ❑ Beta blocker prescribed at d/c (or why not)
- ❑ Thrombolytic within 30 min of arrival
- ❑ I Inpatient death, not comfort measures only or hospice
- ❑ Best practice order set not used
- ❑ Lipid lowering agent at discharge

☐ **HEART FAILURE (Measure(s) failed)**
- ❑ Discharge instructions include:
  - ❑ Activity level
  - ❑ Diet
  - ❑ D/C medications
  - ❑ Follow up apt
  - ❑ Weight monitoring
  - ❑ What to do if symptoms worsen
- ❑ LVF assessment
- ❑ ACE or ARB for LVSD
- ❑ Smoking cessation counseling
- ❑ Inpatient death, not comfort measures only or hospice
- ❑ Best Practice order set not used

☐ **STROKE (Measure(s) failed)**
- ❑ Initial NIH
- ❑ Second NIH
- ❑ Time and date of imaging
- ❑ Dysphagia Screening
- ❑ TPA considered
- ❑ Decubitus ulcer assessed
- ❑ Lipids
- ❑ DVT Prophylaxis within 48 hours of arrival
- ❑ Anti-thrombotic therapy prescribed
- ❑ Rehab screening
- ❑ Smoking education
- ❑ Discharge instructions
- ❑ Anticoagulation

Additional Information from Abstractor:

☐ **SURGICAL CARE IMPROVEMENT PROJECT (SCIP) (Measure(s) failed)**
- ❑ Hair removal
- ❑ Antibiotics given <1 hours prior to incision
- ❑ Normo-thermia immediately post-op/colon pts.
- ❑ Antibiotic stopped < 24 hours
- ❑ Beta Blocker not given
- ❑ VTE Prophylaxis < 24 hours
- ❑ Preferred Antibiotics given
- ❑ Recommended VTE Prophylaxis

Surgical procedure _____

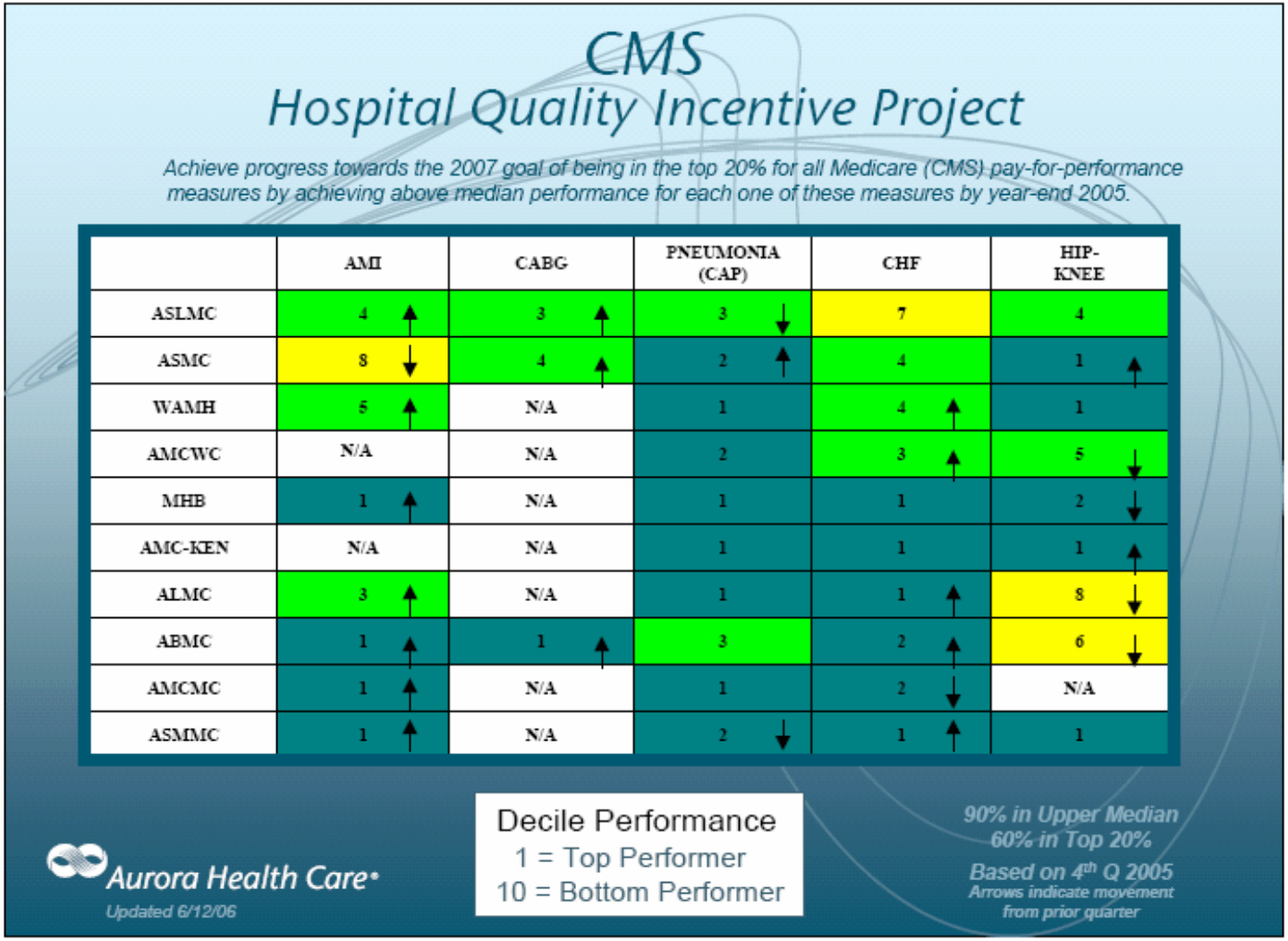
☐ **Manager**: Review with involved employee. Return to Care Management/Quality Dept. within 7 days.
Name(s) of employee:_____
Action plan: _____
Manager Signature: _____ Date: _____

☐ **Physician**: _____ Review above outlier. Return to Medical Staff Office/ Care Management/Quality Dept. within 7days.
Comments: _____
_____
Physician signature: _____ Date: _____

If you have questions please contact Quality Review Nurse. ☐ **Debbie X5861** ☐ **Vicki X5869** ☐ **Barb X5860**

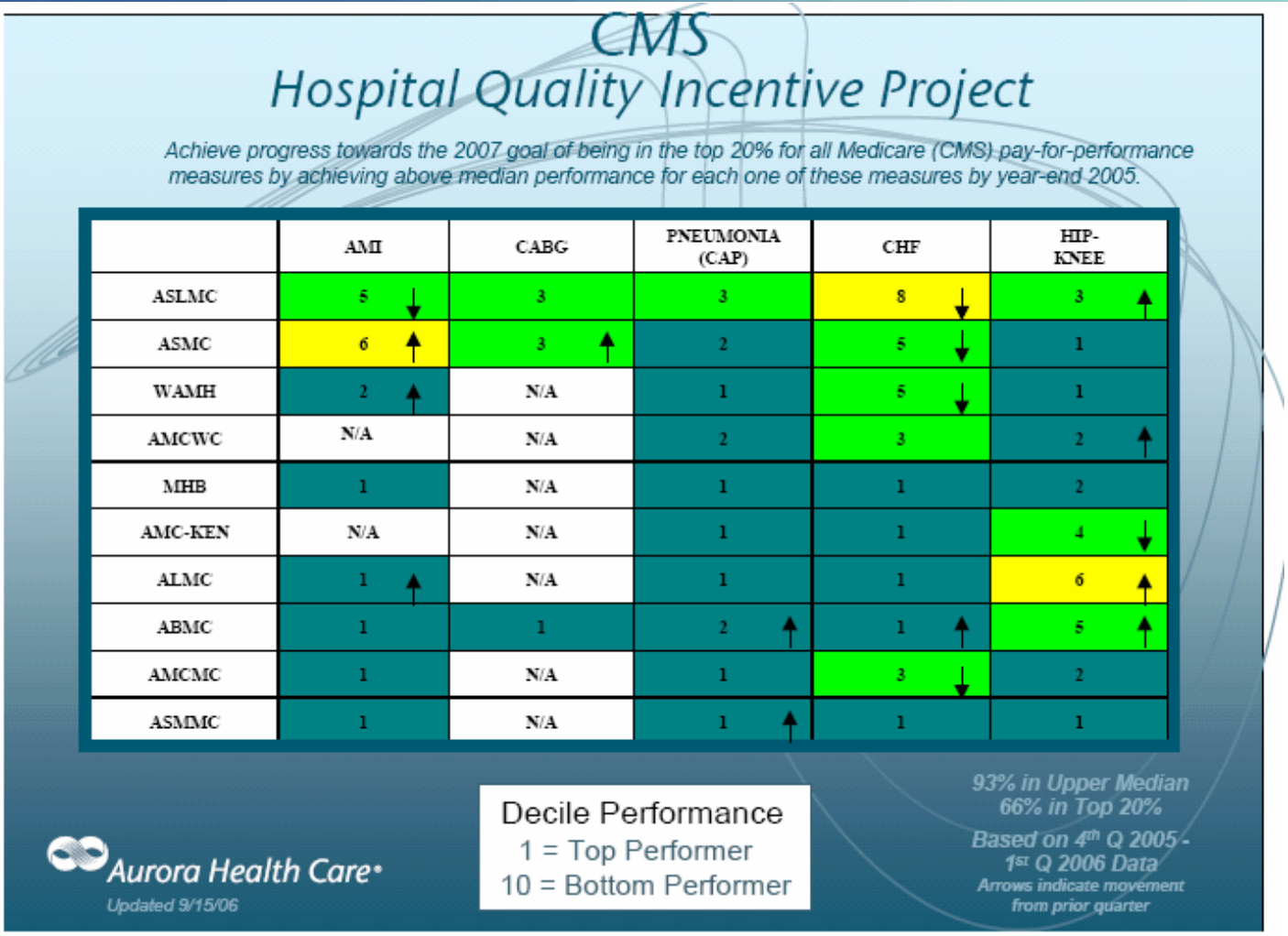
CONFIDENTIAL - NOT A PART OF THE MEDICAL RECORD

Unique Improvement Tools



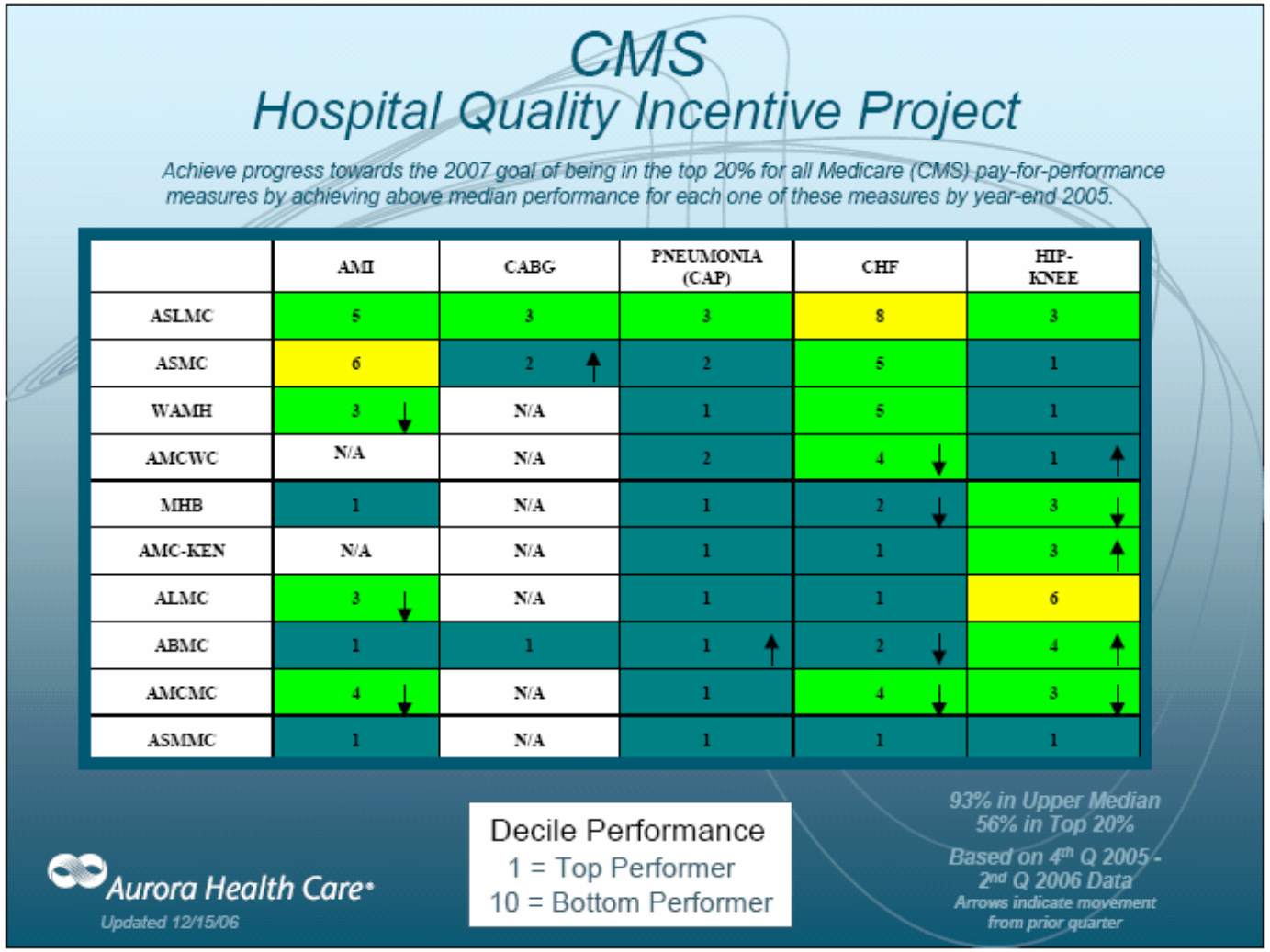
	AMI	CABG	PNEUMONIA (CAP)	CHF	HIP-KNEE
ASLMC	4 ↑	3 ↑	3 ↓	7	4
ASMC	8 ↓	4 ↑	2 ↑	4	1 ↑
WAMH	5 ↑	N/A	1	4 ↑	1
AMCWC	N/A	N/A	2	3 ↑	5 ↓
MHB	1 ↑	N/A	1	1	2 ↓
AMC-KEN	N/A	N/A	1	1	1 ↑
ALMC	3 ↑	N/A	1	1 ↑	8 ↓
ABMC	1 ↑	1 ↑	3	2 ↑	6 ↓
AMCMC	1 ↑	N/A	1	2 ↓	N/A
ASMMC	1 ↑	N/A	2 ↓	1 ↑	1

Unique Improvement Tools



	AMI	CABG	PNEUMONIA (CAP)	CHF	HIP-KNEE
ASLMC	5 ↓	3	3	8 ↓	3 ↑
ASMC	6 ↑	3 ↑	2	5 ↓	1
WAMH	2 ↑	N/A	1	5 ↓	1
AMCWC	N/A	N/A	2	3	2 ↑
MHB	1	N/A	1	1	2
AMC-KEN	N/A	N/A	1	1	4 ↓
ALMC	1 ↑	N/A	1	1	6 ↑
ABMC	1	1	2 ↑	1 ↑	5 ↑
AMCMC	1	N/A	1	3 ↓	2
ASMMC	1	N/A	1 ↑	1	1

Unique Improvement Tools



CMS
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	AMI	CABG	PNEUMONIA (CAP)	CHF	HIP-KNEE
ASLMC	5	3	3	8	3
ASMC	6	2 ↑	2	5	1
WAMH	3 ↓	N/A	1	5	1
AMCWC	N/A	N/A	2	4 ↓	1 ↑
MHB	1	N/A	1	2 ↓	3 ↓
AMC-KEN	N/A	N/A	1	1	3 ↑
ALMC	3 ↓	N/A	1	1	6
ABMC	1	1	1 ↑	2 ↓	4 ↑
AMCMC	4 ↓	N/A	1	4 ↓	3 ↓
ASMMC	1	N/A	1	1	1

Aurora Health Care

Updated 12/15/06

Decile Performance
1 = Top Performer
10 = Bottom Performer

93% in Upper Median
56% in Top 20%

Based on 4th Q 2005 - 2nd Q 2006 Data

Arrows indicate movement from prior quarter

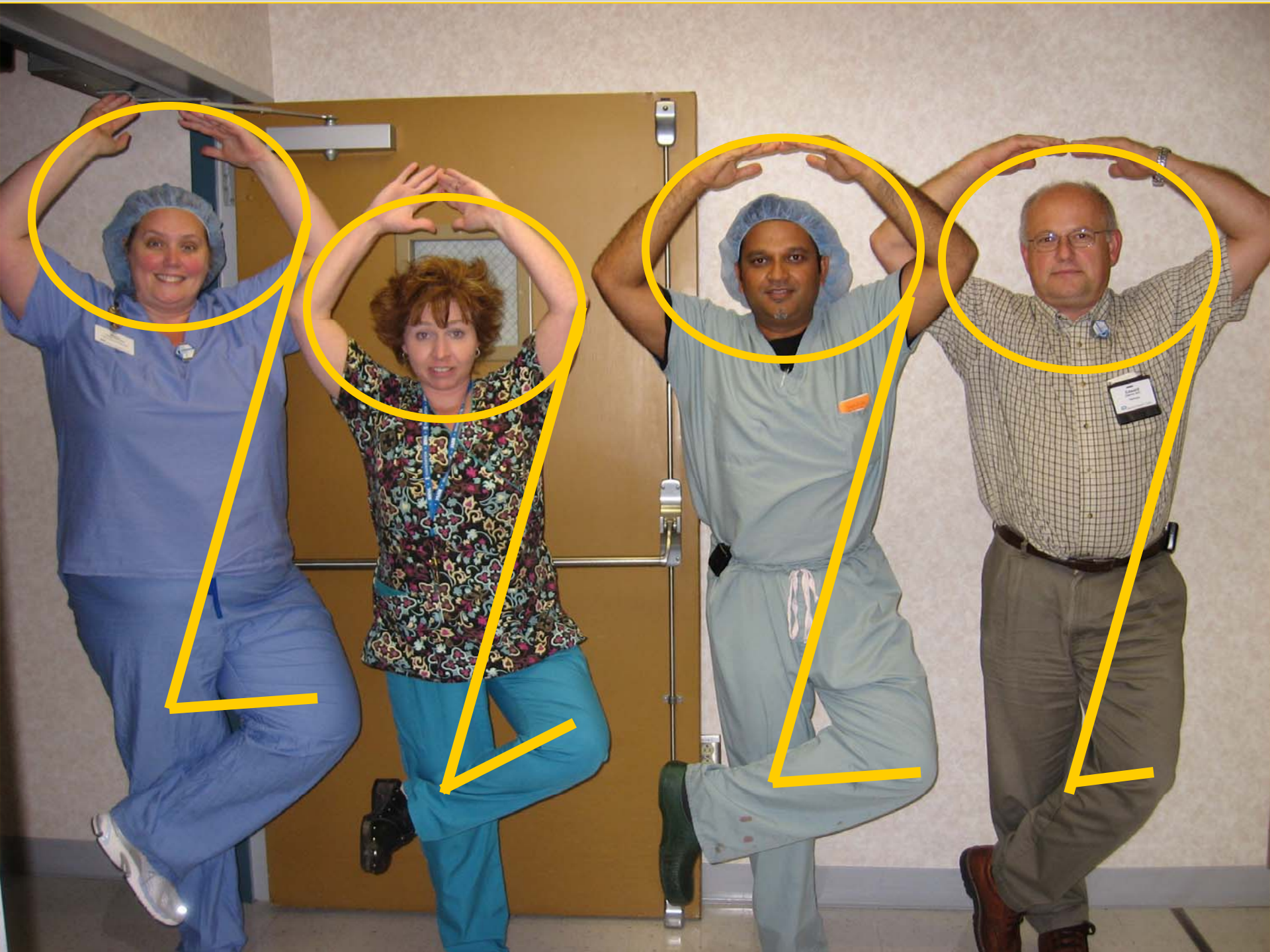
Unique Improvement Tools

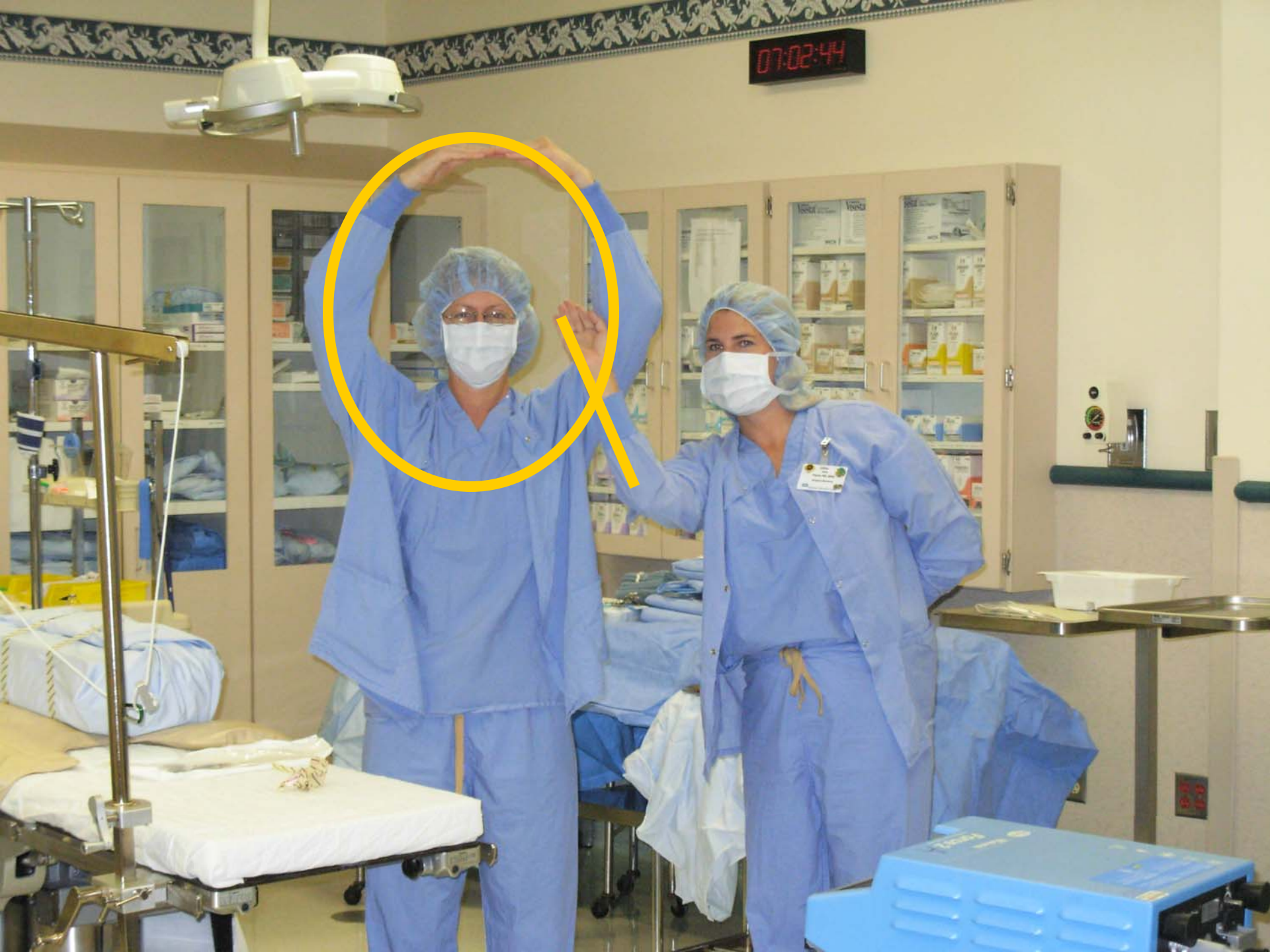
Make it . . .

real

timely

personal

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Unique Improvement Tools

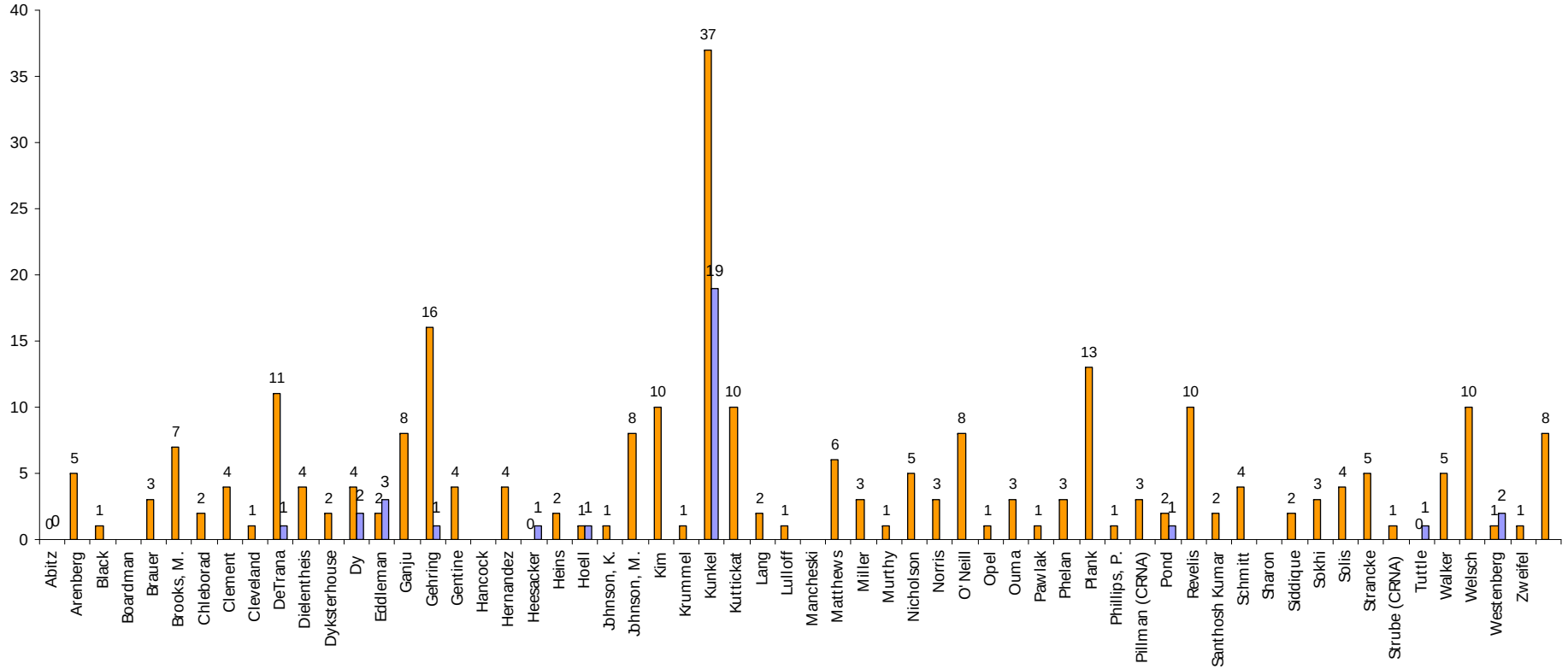
Make it . . .

real

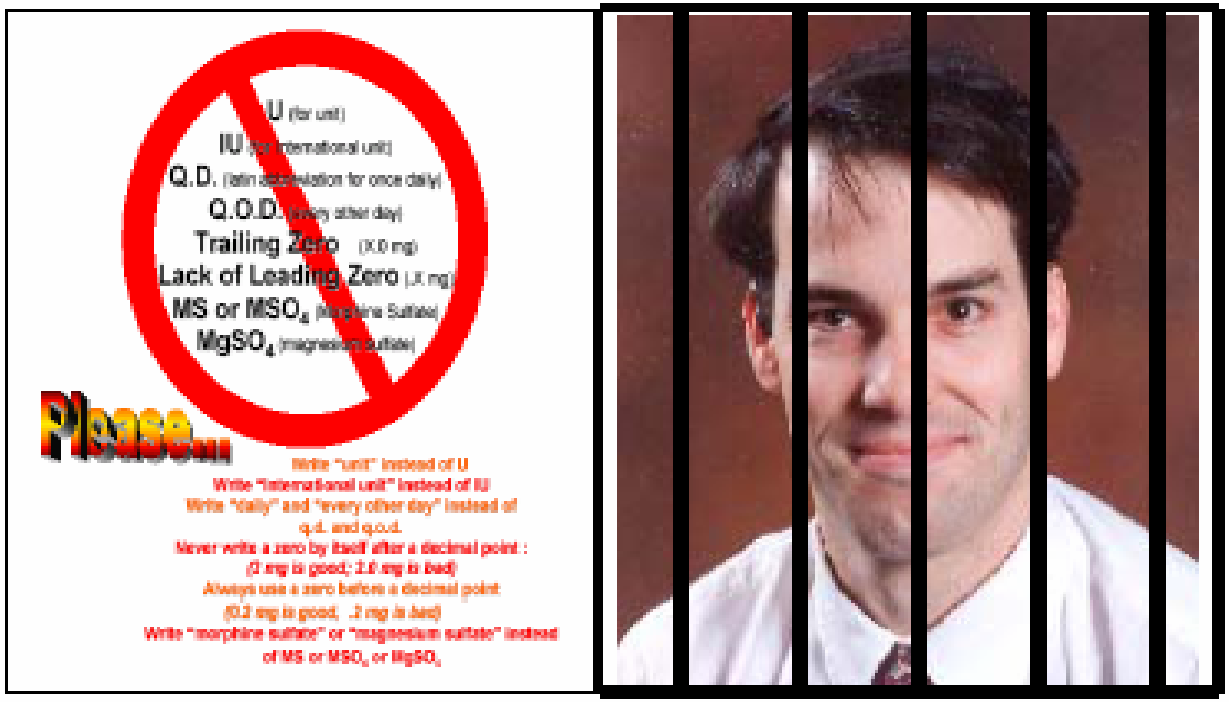
timely

personal

Unique Improvement Tools



Unique Improvement Tools



Premier Pre-Conference Agenda
Advanced Strategies in Hospital Pay for Performance

- **8:30 AM – Welcome and Introductions**
  - Frank Johnson, Vice President, Premier, Inc., Charlotte, NC
- **8:45 AM – Top Performer Strategies**
  - Jan McNeilly RN, Director, Premier Inc., Charlotte, NC
- **9:15 AM – Rapid Clinical Improvements for Hospital-wide Success**
  - Dan Grigg and Kristin Myers, Center for Patient Safety & Clinical Effectiveness, Salem Hospital
- **10:00 – Break**
- **10:15 – System-wide Approach to Clinical Improvements**
  - Ginny Ripslinger, AVP, Knowledge Management, St. Joseph's Health System
- **11:00 – Unique Improvement Tools from an HQID Top Performer**
  - Lori Knitt, Director of Medical Staff / Quality Services, Aurora Sheboygan Memorial Hospital
- **11:45 – Next Steps in P4P – QUEST: High Performing Hospitals Program**
  - Frank Johnson, Vice President, Premier, Inc., Charlotte, NC
- **12:00 – Adjourn**

Proven Results in P4P Demonstration

CMS/Premier P4P Demonstration extension was awarded in 2007 to expand the project and continue to measure the effects of financial incentives on hospital performance

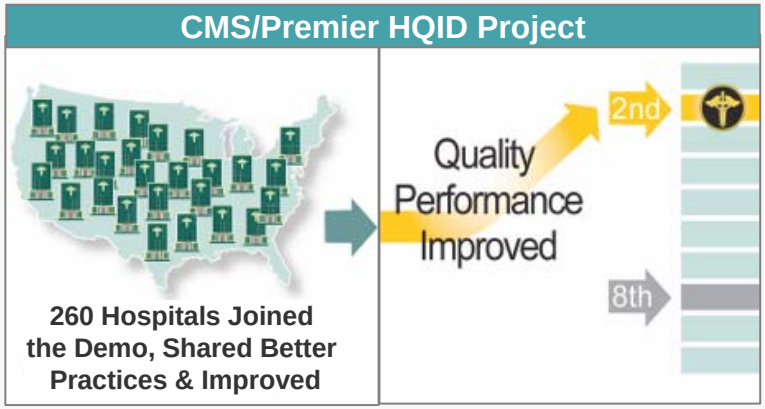
CMS Applauds Premier and HQID Learnings Transforming Healthcare to Higher Quality, More Efficient Care

"The CMS/Premier Hospital Quality Incentive Demonstration has been a tremendous learning opportunity for CMS, informing our efforts to transform the Medicare program from passive payer to active purchaser of higher quality, more efficient care.

The HQID has shown that financial incentives and public recognition, are powerful motivators of performance improvement, as assessed by evidence-based quality measures.

The success of the demonstration has provided CMS with the impetus and confidence to move forward with the Medicare Hospital Value-Based Purchasing Plan, which was detailed in our recently released Report to Congress. "

Official - Centers for Medicaid & Medicare



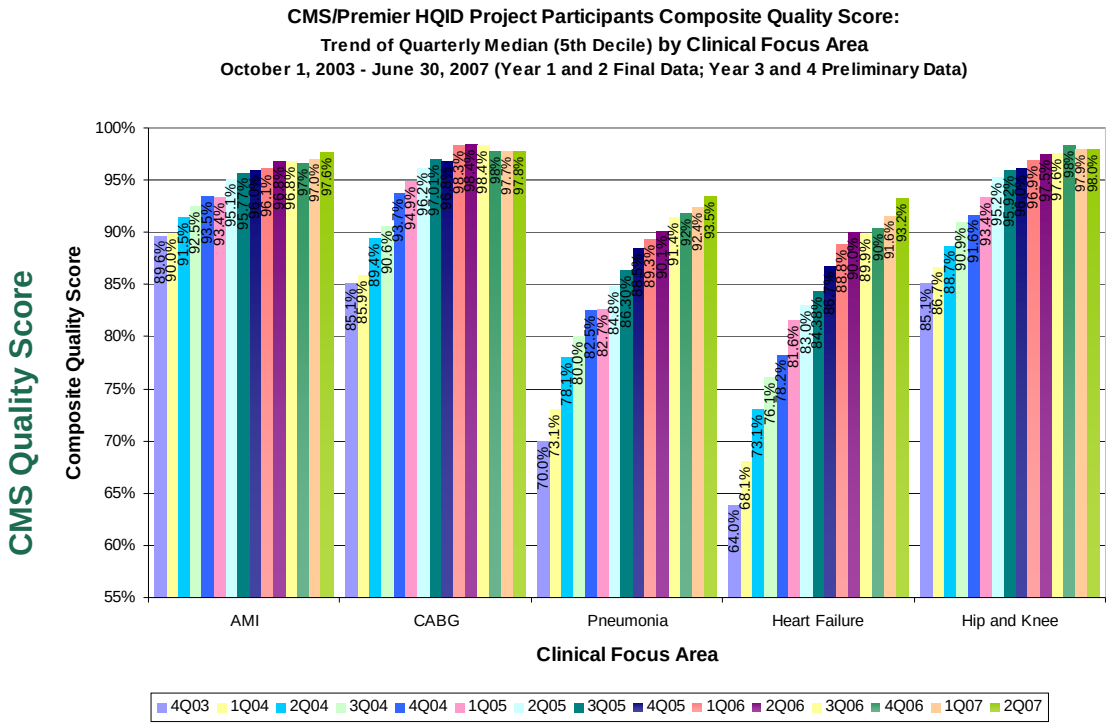
Dramatic and Sustained Improvement

Avg. improvement across all clinical areas for median CQS

17.3%

Clinical Area	Percent Improvement
AMI	8.0%
CABG	12.7%
Pneumonia	23.5%
Heart Failure	29.3%
Hip & Knee	12.9%

CMS HQID Quality Score



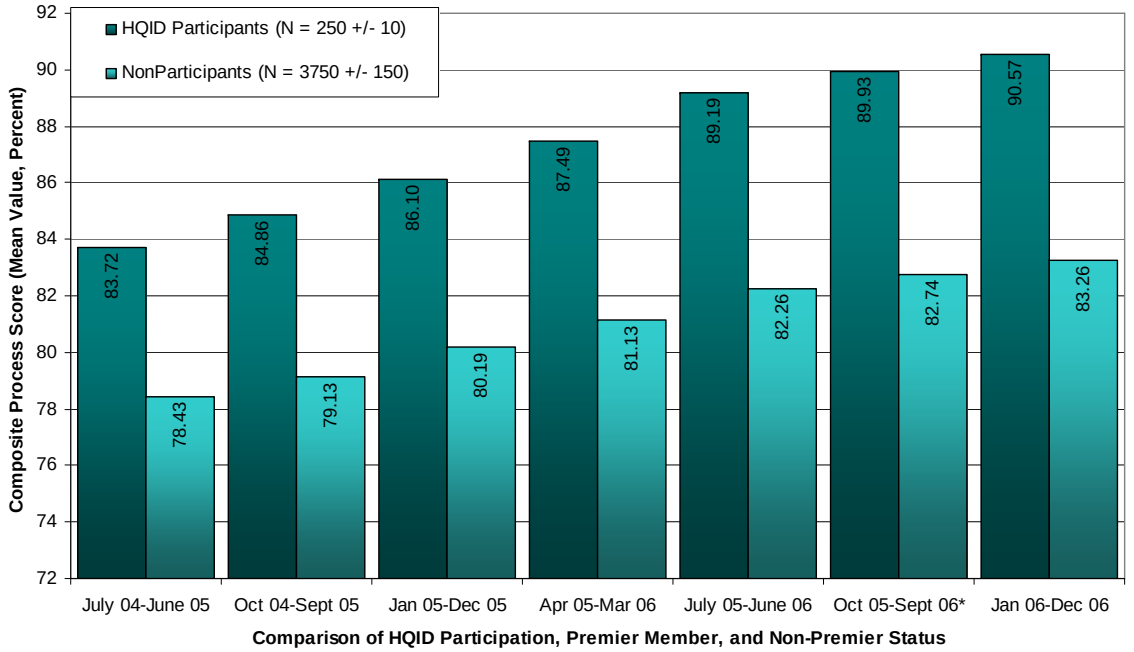
In Broader Comparison, HQID Hospitals Excel

National Leaders in Quality Performance

- HQID participants avg. 6.4% higher than Non-Participants
- Avg. improvement for HQID participants = 6.8%
- Avg. improvement for Non-participants = 4.8%
- New England Journal of Medicine publication by Lindenauer et al. (February 2007) found that hospitals engaged in P4P achieved quality scores 2.6 to 4.1 percentage points above other hospitals due solely to the impact of P4P incentives.

HQID hospitals have higher quality ratings* than national hospitals overall

*CMS process score



*Beginning with Oct 05-Sept 06 the influenza vaccination measure became unsuppressed and the number of process measures increased from 18 to 19

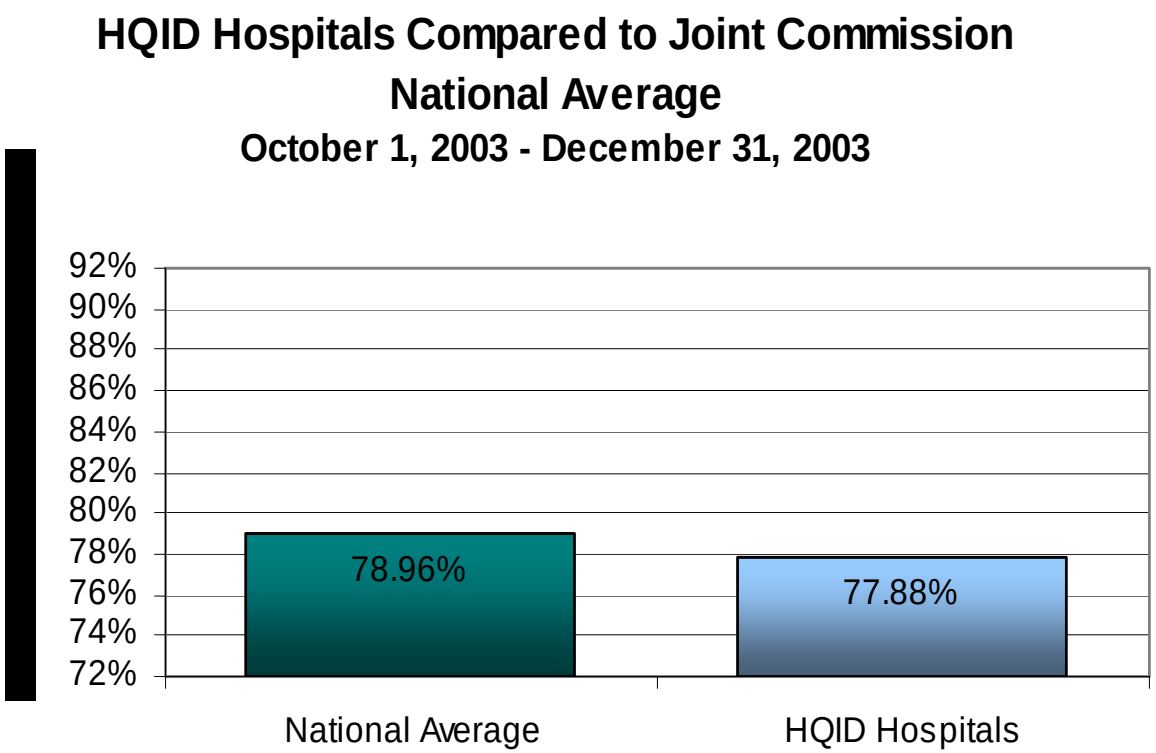
A composite of 19 measures shared in common between HQID and Hospital Compare shows P4P hospitals performing above the nation as a whole

HQID Hospitals Started Project at National Average

HQID hospitals did not have higher quality ratings* than national hospitals overall at the beginning of the project

*Composite process score

A composite of 14 measures shared in common between HQID and the Joint Commission Comparative for the first quarter of the project shows P4P hospitals performing below the nation as a whole.

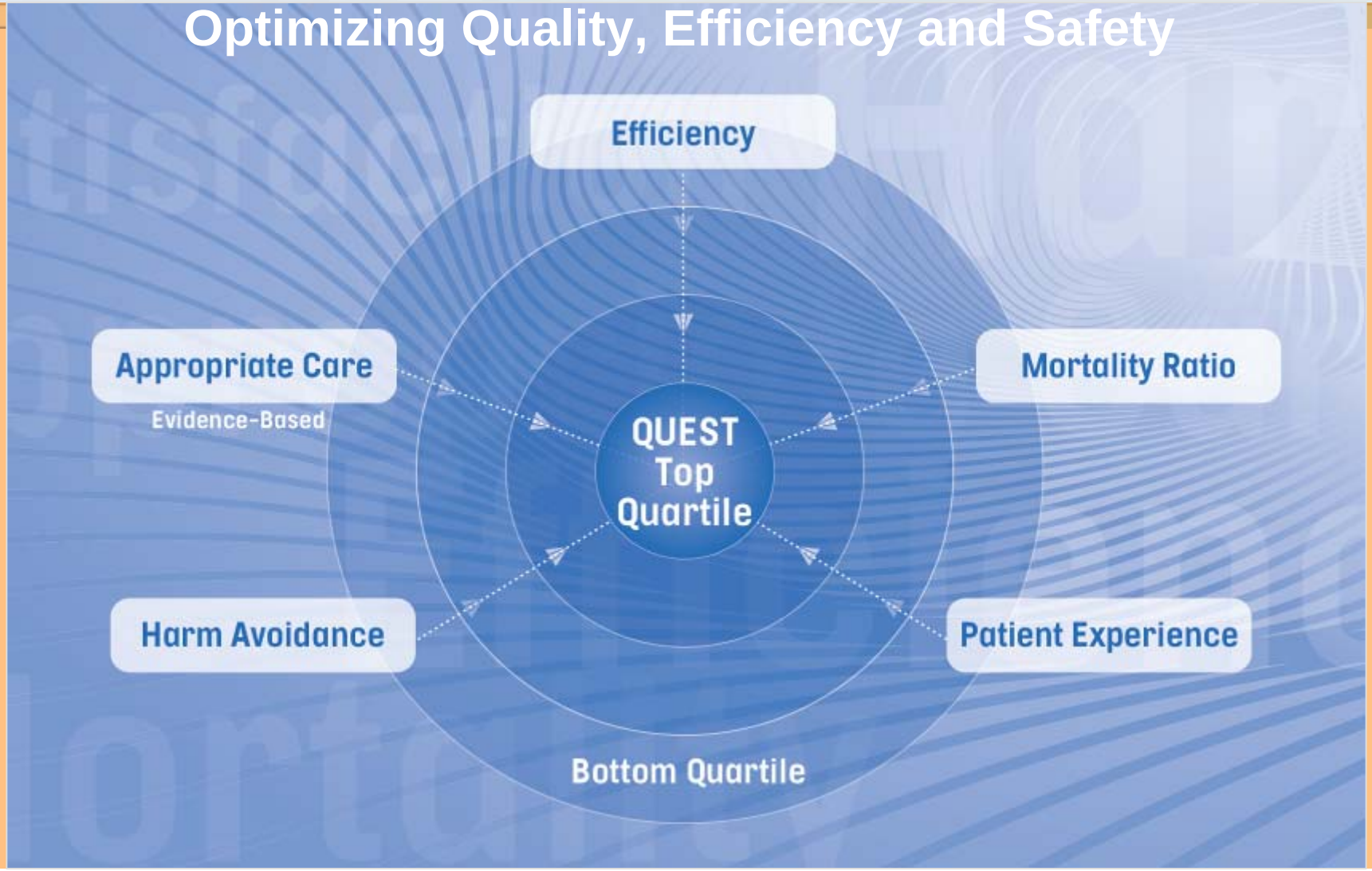


P4P Legislation Update

- CMS released to Congress a value-based purchasing (VBP) plan on November 21, 2007, as required by the Deficit Reduction Act
  - Congress must pass legislation to implement the plan – considering action in 2008
  - Premier has developed draft policy principles based on experience with the HQID to guide its discussions with Congress
- CMS VBP design:
  - Builds on Hospital Quality Data for Annual Payment Update Program (RHQDAPU)
  - Three year phase-in: Yr 1 = only for reporting; Yr. 2 = 50% on performance; Yr. 3 = 100% performance
  - Rewards paid for the higher of attainment & improvement levels, but thresholds to be decided by Congress
  - Each hospital would get a composite score based on a roll up of all measures; proposes starting with 20 measures
  - No new money - Incentive payments funded by 2 – 5% of DRGs. But, no time lag in payments (portion of hospitals' DRG payment to be determined based on performance under VBP in a prior period).
  - Unallocated funds (money not paid due to poor performance) could be used to reward high performers or be returned to Government

Future Large-Scale Collaboration

Launching here at IHI Forum



Thank you