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
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
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
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
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
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

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

Tostitos
FIESTA BOWL
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

Intervention
(Appropriate Action)

Measure Conformance

Validate Competency

Educate

Focus/PDSA/
Rapid Cycle Design

LINE MANAGERS
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

LVF Assessment

% Compliance

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
Smoking Cessation Advice: Educate/Validate Competency

- Monthly Staff Announcement
- Removal of old Forms from stock
Smoking Cessation Advice: Measure Conformance

Smoking Cessation Advice

% Compliance

AMI
HF
PNE
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

Antibiotics within 1 Hour of Incision

% Compliance

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
• 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

Antibiotics < 4 Hours PNE

% Compliance

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

Blood Cultures before Antibiotics in ED

% Compliance

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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
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

• Strategic Priorities
  – Sacred Encounters
  – Perfect Care
  – Healthiest Communities
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
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?
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)
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
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
Challenges

- Creating shared vision
- Physician accessibility
- Physician partnerships – buy in and alignment
- Cost of Information Technology
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
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
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
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.
SJHS Landscape Today
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 an 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

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

## CMS

### Hospital Quality Incentive Project

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<th>AMI</th>
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**Decile Performance**

1 = Top Performer
10 = Bottom Performer

*Based on 4th Q 2003 Data*
Unique Improvement Tools

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<tr>
<th>Area/Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate/Index</th>
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<th>HQI Decile Threshold Score</th>
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Unique Improvement Tools
Unique Improvement Tools
Unique Improvement Tools
Unique Improvement Tools
## Unique Improvement Tools

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Unique Improvement Tools

ASMMC CMS Stats - Percent of compliance AMI

AMI Aspirin on Arrival

Aspirin prescribed at discharge
# 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.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>AMI</th>
<th>CABG</th>
<th>PNEUMONIA (CAP)</th>
<th>CHF</th>
<th>HIP-KNEE</th>
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<td>5</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

**Decile Performance**

1 = Top Performer

10 = Bottom Performer

---

67% in Top Median Based on 4th Q 2004 Data

Arrows indicate movement from prior quarter

Aurora Health Care

Updated 6/13/05
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.

<table>
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<th>AMI</th>
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<th>HIP-KNEE</th>
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Decile Performance
1 = Top Performer
10 = Bottom Performer

Aurora Health Care
Updated 10/10/05

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

<table>
<thead>
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<th>CHF</th>
<th>HIP-KNEE</th>
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</table>

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

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

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<thead>
<tr>
<th>Date Reviewed</th>
<th>Diagnosis/Classification</th>
<th>Diagnostic Tests/Results</th>
<th>Treatment rendered</th>
<th>Agree Y or N</th>
<th>Comments</th>
</tr>
</thead>
</table>

** 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
Unique Improvement Tools

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
S-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)
## HQI Attending Physician Summary Report

Medicare Provider: 520035 AURORA SHEBOYGAN MEM MED CTR  
Attending Physician: SCHROEDER, GEORGE - SHEBOYGAN MEMORIAL MEDICAL CTR  
8/25/2005 1:38 PM

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<th>Measures</th>
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<th>Medicare Provider CFG Sample</th>
<th>Medicare Provider CFG Cases</th>
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Unique Improvement Tools
## Unique Improvement Tools

### Heart Failure Physician Feedback

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<th>Quarter</th>
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<th>DC DOW</th>
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<td>Friday</td>
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<td>2/ 3/2007</td>
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<td>3/18/2006</td>
<td>Thursday</td>
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<td>Nursing Documentation</td>
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<td>Q1 2006</td>
<td>1/ 3/2006</td>
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<td>Diagnosis confusion/delay</td>
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<td>Q1 2007</td>
<td>4/10/2007</td>
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<td>70</td>
<td>Multiple process issues</td>
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<td>5/19/2007</td>
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<td>6/17/2006</td>
<td>Saturday</td>
<td>81</td>
<td></td>
<td>Nursing Documentation</td>
</tr>
</tbody>
</table>
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.
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 Knott, 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 #185915: XNNAMEXX, this 88-year-old female was brought to the MMC ED at 2051 on 7/12/2004 by ambulance with c/o chest pain. Dr. R. is the ED physician on duty. ED RNs include Kim P, RN and K. D., NE. The patient’s primary physician, Dr. M was contacted by ED staff at 0006 and arrived in the ED by 2005. 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 F & F 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

© 2005 by the American College of Cardiology Foundation and the American Heart Association, Inc.

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 receiving 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

<table>
<thead>
<tr>
<th>Pneumonia</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gina Hotrod</td>
<td>Richard Miller</td>
<td>Deborah Miller - Flu vaccine not given</td>
</tr>
<tr>
<td>Neil Armstrong</td>
<td>Mary Star</td>
<td>Carolyn Conner - Flu vaccine not given</td>
</tr>
<tr>
<td>David Miller</td>
<td>Elfrieda Panos</td>
<td>Elizabeth Dole - Abx &gt;4 hrs</td>
</tr>
<tr>
<td>Donald Duck</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart Failure</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hulda Zulda</td>
<td>Claude VanDamm</td>
<td>All patients met measures</td>
</tr>
<tr>
<td>Donald Diller</td>
<td>Bonnie Boop</td>
<td>John Kampman</td>
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</table>

<table>
<thead>
<tr>
<th>AMI</th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim Kennedy</td>
<td></td>
<td>All patients met measures</td>
</tr>
</tbody>
</table>

Note: not all cases will be in final CMS population
# Unique Improvement Tools

## Aurora Health Care* 
**Quality Outlier Response Form**
Based on PREDICTIVE abstraction, this case has not met the "Best Practice" guidelines.

### COMMUNITY ACQUIRED PNEUMONIA (Measure(s) Failed)
- Blood cultures before antibiotic
- Blood cultures in 48 hours
- Antibiotics > 4 hours after arrival
- Preoperative antibiotic selection/combination or combination
- Pneumococcal vaccination
- Influenza vaccination
- Smoking cessation counseling
- Smoking cessation not documented at discharge or hospital
- Best Practice order not used

### HEART FAILURE (Measure(s) Failed)
- Discharge instructions: 
  - Activity level
  - Diet
  - Diuretic medications
  - Follow up plan
  - Weight monitoring
  - What to do if symptoms worsen
  - LVF assessment
  - ACE or ARB for LVSD
  - Smoking cessation counseling
  - Smoking cessation not documented at discharge or hospital
  - Best Practice order not used

### STROKE (Measure(s) Failed)
- Intravenous Hyaluronic Acid
- Second MRI
- Tissue and data of imaging
- TPA considered
- Decubitus ulcer assessment
- Safety
- DVT prophylaxis within 48 hours of admission
- Anti-thrombosis therapy prescribed
- Intravascular catheter screening
- Smokin education
- Discharge instructions
- Anti-coagulation

### SURGICAL CARE IMPROVEMENT PROJECT (SCIP) (Measure(s) Failed)
- Hair removal within 24 hours prior to incision
- Non-narcotic analgesia immediately post-op: 6 hours
- Antibiotics stopped > 24 hours
- Beta blocker not given
- VTE prophylaxis within 48 hours
- Preferred Anti-coagulation
- Recommended VTE prophylaxis

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

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

If you have questions please contact Quality Review Nurse. □ Debbie X5661 □ Vicki X5669 □ Barb X5660

CONFIDENTIAL - NOT A PART OF THE MEDICAL RECORD
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.

<table>
<thead>
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<th>PNEUMONIA (CAP)</th>
<th>CHF</th>
<th>HIP-KNEE</th>
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<tr>
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<td>1</td>
<td>2</td>
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</tr>
<tr>
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<td>5</td>
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<tr>
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<td>3</td>
<td>2</td>
<td>6</td>
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<tr>
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Decile Performance
1 = Top Performer
10 = Bottom Performer
## 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.

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**Decile Performance**

1 = Top Performer
10 = Bottom Performer

93% in Upper Median
66% in Top 20%
Based on 4th Q 2005 - 1st Q 2006 Data
Arrows indicate movement from prior quarter

Aurora Health Care
Updated 9/15/06
## 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.

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</tbody>
</table>

**Decile Performance**

1 = Top Performer  
10 = Bottom Performer
Unique Improvement Tools

Make it . . .

real

timely

personal
Unique Improvement Tools

Make it . . .

real
timely
personal
Unique Improvement Tools
Unique Improvement Tools

Physician "Most Wanted"

- U (for unit)
- IU (international unit)
- Q.D. (Latin abbreviation for once daily)
- Q.O.D. (every other day)
- Trailing Zero 
- Lack of Leading Zero 
- MS or MSO₄ (magnesium sulfate) 
- MgSO₄ (magnesium sulfate)

Please:
- Write "unit" instead of U
- Write "international unit" instead of IU
- Write "daily" and "every other day" instead of q.d. and q.o.d.
- Never write a zero by itself after a decimal point:
  - (2.6 mg is good; 2 mg is bad)
  - Always use a zero before a decimal point:
    - (0.2 mg is good; 2 mg is bad)
- Write "morphine sulfate" or "magnesium sulfate" instead of MS or MSO₄ or MgSO₄
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%

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Percent Improvement</th>
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<tr>
<td>AMI</td>
<td>8.0%</td>
</tr>
<tr>
<td>CABG</td>
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<tr>
<td>Pneumonia</td>
<td>23.5%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>29.3%</td>
</tr>
<tr>
<td>Hip &amp; Knee</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

CMS HQID Quality Score

CMS/Premier HQID Project Participants Composite Quality Score:
Trend of Quarterly Median (5th Decile) by Clinical Focus Area
October 1, 2003 - June 30, 2007 (Year 1 and 2 Final Data; Year 3 and 4 Preliminary Data)
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

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.

HQID Hospitals Compared to Joint Commission
National Average
October 1, 2003 - December 31, 2003

<table>
<thead>
<tr>
<th>National Average</th>
<th>HQID Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>78.96%</td>
<td>77.88%</td>
</tr>
</tbody>
</table>
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

Optimizing Quality, Efficiency and Safety
Thank you