Working With Your Hospitals on Quality Improvement: From Small Steps to Large Leaps

John Bott, Agency for Healthcare Research and Quality
Mari Tietze, Dallas-Fort Worth Hospital Council
Benjamin Jacob, Dallas-Fort Worth Hospital Council
Diane Stewart, Pacific Business Group on Health

July 27th, 2009

Using the “Raise Hand” Button for Questions

❖ If you have questions during the Q&A session, please use the Raise Hand function; you will be placed into a queue to ask your question.

To ask a question, click on the **Raise Hand** button in the Participants Panel and the Host will un-mute your line.

Once your question has been answered, please click the **Lower Hand** icon and the Host will mute your line.

Agency for Healthcare Research and Quality

Advancing Excellence in Health Care www.ahrq.gov

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Questions

We will have three opportunities throughout the Web conference for you to ask questions of our speakers. To do so, please:

- At any time, post your questions in the Q&A box on the right-hand side of your screen and press “send” to “all panelists”

OR

- Click the “raise your hand” button to be un-muted and introduced to verbally ask a question

Agenda

- Welcome and Introduction
- Quality Improvement Overview
- Questions and Answers
- Dallas-Fort Worth Hospital Council Example
- Questions and Answers
- Pacific Business Group on Health Example
- Questions and Discussion

Web Conference Schedule

Orientation:

October - Designing Your Reporting Program

Measures/Data/Analysis:

November - Selecting Measures & Data

December - Key Choices in Analyzing Data for the Report

January - Classifying Hospitals

Reporting/Disseminating/Promoting:

February - Displaying the Data

March - Web Site Design & Content

April - Getting the Public To View and Use Your Report

Evaluation:

May - Evaluation of Public Reporting Program

Quality Improvement:

July - Working With Your Hospitals on Quality Improvement: From Small Steps to Large Leaps

Q&A Web Forum- August 12th

Poll Question

What is your organization's experience with working on quality improvement with health care provider organizations? (Please choose one.)

- Some experience as it relates to our public report
- A lot of experience as it relates to our public report
- Some experience unrelated to our public report
- A lot of experience unrelated to our public report
- No experience

Today's Learning Objectives

- Raise awareness of the opportunity to work on quality improvement with hospitals that appear in your public report
- Understand hospitals' capacities to engage in quality improvement related to areas measured in your report
- Once a public report card is in place, understand strategies used by others to foster the spread of best practices among providers
- Learn from case examples the cost/benefit associated with strategies for facilitating peer-to-peer learning

Poll Results

Please find the poll results on the right-hand side of your screen.

❑ Some experience as it relates to our public report	41%
❑ A lot of experience as it relates to our public report	27%
❑ Some experience unrelated to our public report	5%
❑ A lot of experience unrelated to our public report	9%
❑ No experience	18%

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Seeing the Opportunity

- There will be opportunities to join with hospitals on quality improvement (QI) that you are publicly reporting on
  - Requests for assistance may be direct or indirect
  - You may want to offer assistance given your proximity to the data & quality measure results
- A chance to think about your organization's role in QI prior to issuing your public report
  - How you would respond if asked for some help
  - Deciding what you may proactively want to provide in an ad hoc or systematic manner

Some Context: Words & Actions

- Words/statements from hospitals may directly or indirectly provide an opportunity to work with hospitals on QI
  - Direct: "Can you tell us what cases were in the numerator?"
  - Indirect: "These results don't tell us where we need to make improvements!"

Some Context: Words & Actions (cont.)

- Actions of hospitals may or may not fit the words
  - Statements made in the press and to the report card sponsor questioning how actionable the results are for QI
  - Meanwhile, hospitals are finding ways to make improvements in the areas measured in the report*
- The upshot: Realize it's a complex dialogue. It's a dialogue that may be productive, for there is often QI work occurring on measures in your report

* Judith Hibbard et al: Health Affairs Mar/Apr '03 & July/Aug '05

Some Context: Quality Improvement Infrastructure

- Lessons learned from surveys conducted regarding QI in measures used in P4P may provide insights:*
  - Providers believed they lacked important resources for achieving the quality goals
  - Some uncertainty as to whether provider organizations had the resources to achieve the quality measures
  - Many thought the incentive wasn't sufficient to offset the cost of making the needed investment in quality infrastructure
- The upshot: Understand the hospitals position and identify QI methods with hospitals that reflect their infrastructure

* Gary Young et al: Health Care Financing Review, Fall '07

Varying Degrees of Engaging in QI with Hospitals

- The next few slides – and the next 2 presentations – provide a sampling of ideas for report card sponsors in working with hospitals on QI
- These examples illustrate:
  - There's not one "right" way to go about QI work. Finding a good fit calls for working locally with your provider community.
  - There's a spectrum of the level of effort that can be expended. It's not all or nothing.

Data & Results: Less Effort

- Compiling & reviewing results with hospitals
- Developing the results with the question in mind: *"What are the measures with more room for improvement?"*
  - Sharing results beyond what will be in your report, such as observed to expected rate
  - Walking through what the results mean… and don't mean, e.g.:
    - What "less than expected" means
    - What "as expected" may not necessarily mean

Data & Results: Less Effort (cont.)

- Navigating across result tables with hospitals (especially in regard to composites)
- In deciding how to navigate through the tables, consider the question: *"What can this tell me about where the problem is occurring?"*
  - For example, for composites, it's helpful to understand what's contributing to the performance in the composite by having the performance in the indicators used in the composite
    - Again, sharing the observed & expected rates for each measure in the composite can shed some light on where to focus on improvement

Data & Results: More Effort

- For all hospitals, stratify their results by options provided within the AHRQ QI software, e.g.:
  - Age category, quarter, risk category
- AHRQ QI software offers three custom stratifiers beyond the canned options
- Beyond the AHRQ QI software customized stratification, you can selectively pull data & send it through the AHRQ QI software, e.g., various AHRQ Clinical Classifications Software (CCS) groupings

Data & Results: More Effort (cont.)

- Performing ad hoc analysis with the data & results, e.g.:
  - Interpretation beyond providing results as noted in previous slides
- Ad hoc data queries, e.g.:
  - Pull each numerator claim for a given measure (if possible given one's data use agreement)

Group Learning: Varying Effort

- Once & done Webinars or in-person events
  - Webinars likely to be preferable with smaller hospitals, rural areas, & dispersed hospitals
  - Use of national experts or leaders in a given community/State as presenters
  - Selecting topics by measures where greatest interest is expressed or most room for improvement
- Ongoing or time limited groups
  - Facilitate/foster interest groups that will work on a QI project that will span several months or years

High-Level QI Environmental Scan

- National QI resources, e.g.:
  - Institute for Healthcare Improvement
  - American Society for Quality – Health care division
- State/local QI resources, e.g.:
  - Quality Improvement Organizations
  - State Hospital Associations
  - Aligning Forces for Quality sites (in select areas)
  - Chartered Value Exchanges

High Level QI Environmental Scan (cont.)

- QI toolkit under development for hospital use to make improvement related to the AHRQ IQIs & PSIs. Some specifics of the toolkit:
  - Methods to evaluate the data for identifying opportunities for improvement
  - Strategies for implementing interventions (or evidence-based best practices)
  - Methods to measure progress
- Available mid-2011

Questions

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Community, Patient Safety and Patient Quality

Dallas-Fort Worth Hospital Council
Education and Research Foundation

Objectives

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- Business Intelligence tool (customize data for hospitals' use)
  - Share reports with individual hospitals
  - Hospitals pull their own data
  - Peer-to-peer improvement
- Patient Safety and Quality Improvement Committee
  - Use IQIs and PSIs for hospital improvement
    - Choose AHRQ QIs to analyze various trends (preselect, survey, by condition)

Dallas-Fort Worth Hospital Council Education and Research Foundation Committee Chart

CMO Executive Forum * CIO Executive Forum * CNO Executive Forum * CFO Executive Forum * HR Executive Forum *

North Texas Healthcare Information and Quality Collaborative (T. Mendoza, B. Jacob, Staff)

- Patient Safety and Quality Committee
- Information Systems Technical Advisory Committee
- Nominating Subcommittee
- Market Product Development Subcommittee
- Executive Committee

Healthcare Workforce Advisory Board (S. Williams, Staff)

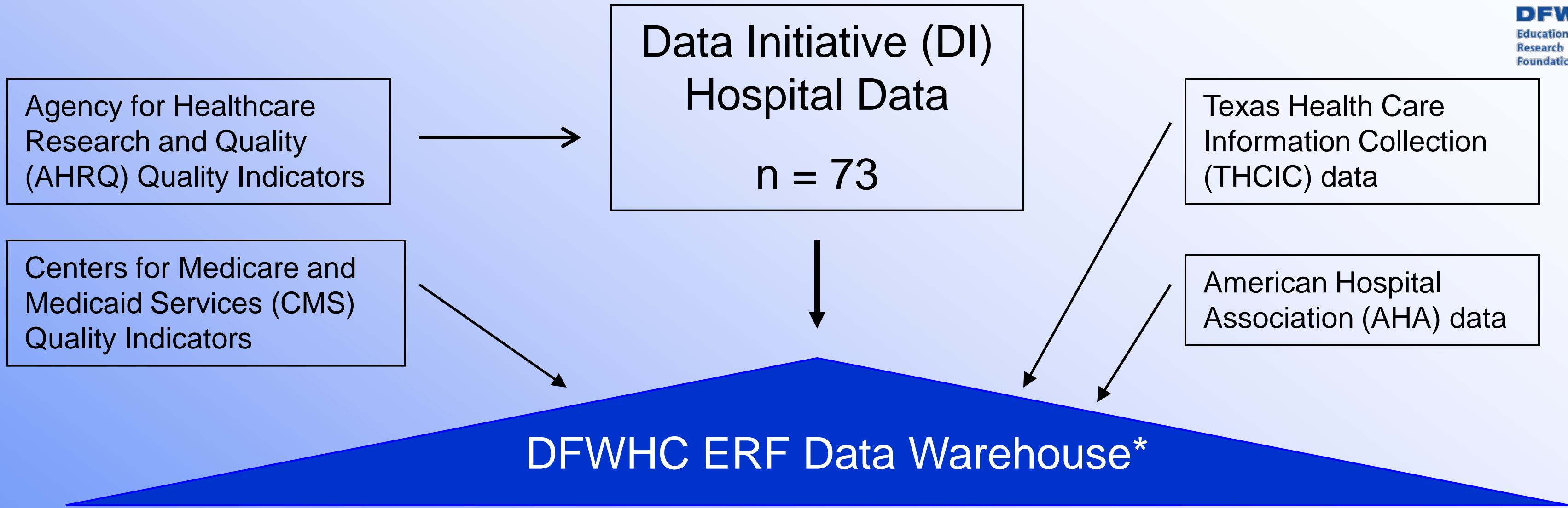
- Healthcare Human Resources Executive Committee
- Human Resources Compensation Committee
- Human Resources Benefits Committee
- Allied Health Professions Collaborative

Research Collaborative (Dr. Tietze, Staff)

Community Health Collaborative (B. Jacob, Staff)

- Community Needs Assessment Council
- Community Health Task Force

DFWHC ERF Data



Data EXCLUSIVE to DFWHC DI Members

6,428,743 DI inpatient records from 1999	**3,933,245 DI outpatient records from 2006**	•DI AHRQ Patient Safety Quality Indicators **(PSI)**	**CMS** Quality Indicators for participating hospitals
•Data available 90 days from close of quarter	•Data available 120 days from close of quarter	•DI AHRQ Inpatient Quality Indicators **(IQI)**	
		•DI AHRQ Pediatric Indicators	

Other Data Available to DFWHC DI Members

20,884,268 THCIC inpatient records from 2000	THCIC AHRQ Patient Safety Indicators **(PSI)**	AHA data
Data available 274 – 365 days from close of quarter	THCIC AHRQ Inpatient Quality Indicators **(IQI)**	
	THCIC AHRQ Pediatric Quality Indicators **(PDI)**	

* = As of December 2008

Location of All Participants

Moore County Hospital District
Collingsworth General Hospital
Knox County Hospital District
Electra Memorial Hospital
Brownfield Regional Medical Center
Paris Regional Medical Center - North
Titus Regional Medical Center
Mitchell County Hospital
Linden Municipal Hospital
El Paso
Ward Memorial Hospital
Henderson Memorial Hospital
Winkler County Memorial Hospital
TX
Palestine Regional Medical Center
McCamey Hospital
Palestine Regional Rehab Hospital
Culberson Hospital
Madison St. Joseph Health Center
Concho County Hospital
Tyler County Hospital
Austin
Huntsville Memorial Hospital
Lillian M Hudspeth Memorial Hospital
Grimes St. Joseph Health Center
Val Verde Regional Medical Center
Houston
Uvalde Memorial Hospital
Palacios Community Medical Center
Jackson County Hospital District
Memorial Medical Center
Refugio County Memorial Hospital District
North Bay Hospital
Starr County Memorial Hospital

Green = rural
Red = critical access
Blue = DFWHC (urban)

Scale Legend
Mile(s)
0 60 120

Outpatient ER Visit – Abdominal Pain NYU Categories [n = 1,250]

Outpatient ER

Hospital XYZ | Year / Qtr | Acuity | Highest Proc Chg-CPT&HCPCS

NYU-ED(%Total) as values	ED1(%Total) Non-Emergent	ED2(%Total) Emergent-PC Care	ED3(%Total) Emergent-ED Care-Prev	ED4(%Total) Emergent-EDCare- Not Prev
Abdom hernia	53.0%	22.1%	0.0%	24.8%
Abdomnl pain	0.0%	67.0%	0.0%	33.0%
Ac renl fail	0.0%	33.3%	0.0%	66.7%
Acute CVD	0.0%	0.0%	0.0%	100.0%
Acute MI	0.0%	0.0%	0.0%	100.0%
Adlt resp fl	0.0%	0.0%	0.0%	100.0%
Allergy	50.7%	21.4%	0.0%	10.3%
Anal/rectal	21.2%	15.2%	0.0%	63.6%
Anemia	50.0%	16.7%	0.0%	33.3%
Appendicitis	0.0%	0.0%	0.0%	100.0%
Asthma	0.0%	1.9%	98.1%	0.0%
Back problem	45.5%	20.2%	0.0%	34.3%
Biliary dx	19.5%	20.0%	0.0%	60.5%
Blindness	0.0%	50.0%	0.0%	50.0%
Bnign ut neo	66.7%	0.0%	0.0%	33.3%
Breast dx	78.6%	21.4%	0.0%	0.0%
Bronchitis	4.3%	75.2%	16.2%	4.3%
Cardia arrst	0.0%	0.0%	0.0%	100.0%
Chest pain	0.0%	47.9%	0.0%	52.1%
chf	0.0%	4.0%	96.0%	0.0%
	25.0%			

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Inpatient Quality Indicators

Patient Safety Indicators

Pediatric Quality Indicators

N = 52

AHRQ Patient Safety Indicators

AHRQ Patient Safety Indicators
Accidental Puncture or Laceration Per 1000 cases
Birth Trauma - Injury to Neonate Per 1000 cases
Complications of Anesthesia Per 1000 cases
Death among Surgical Inpatients w/ Complications Per 1000 cases
Death in Low Mortality DRGs Per 1000 cases
Decubitus Ulcer Per 1000 cases
Iatrogenic Pneumothorax Per 1000 cases
Obstetric Trauma - Cesarean Section Per 1000 cases
Obstetric Trauma - Vaginal w/ Instrument Per 1000 cases
Obstetric Trauma - Vaginal w/o Instrument Per 1000 cases
Post-Op Hemorrhage or Hematoma Per 1000 cases
Post-Op Hip Fracture Per 1000 cases
Post-Op Physiologic and Metabolic Derangements Per 1000 cases
Post-Op Pulmonary Embolism or Deep Vein Thrombosis Per 1000 cases
Post-Op Respiratory Failure Per 1000 cases
Post-Op Sepsis Per 1000 cases
Post-Op Wound Dehiscence Per 1000 cases
Selected Infections Due to Medical Care Per 1000 cases
Transfusion Reaction Per 1000 cases
Comp: Patient Safety for Selected Indicators

N = 19 indicators and 1 composite score

Hospital XYZ, AHRQ Death Among Surgical Patients With Complications Risk Adjusted Rate per 1,000 Cases Compared to Peers

Could "Drill-thru" to these records

Risk Adjusted Rate

300.00
250.00
200.00
150.00
100.00
50.00
0.00

2004 Q 1 | 2004 Q 2 | 2004 Q 3 | 2004 Q 4 | 2005 Q 1 | 2005 Q 2 | 2005 Q 3 | 2005 Q 4 | 2006 Q 1 | 2006 Q 2 | 2006 Q 3 | 2006 Q 4 | 2007 Q 1 | 2007 Q 2 | 2007 Q 3 | 2007 Q 4 | Forecast1 | Forecast2 | Forecast3 | Forecast4

Hospital XYZ [designated with arrow] and key peer hospitals

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CMS Quality Indicators

Compliance Rates

Comparative CMS Indicator Compliance Rates

CMS Quality Indicators New

CMS Indicator | Date / Quarter | Hospitals | Critical Access | Rural Partnership/Grant | Rate of Compliance

Rate of Compliance as values		2005	2006	2007	Date / Quarter
AMI Class	AMI ACEI or ARB for LVSD	88.04%	89.61%	95.55%	90.86%
	AMI Adult Smoking Cessation Advice/Counseling	/0	98.71%	98.45%	98.53%
	AMI Aspirin at Arrival	94.99%	97.20%	97.14%	96.40%
	AMI Aspirin Prescribed at Discharge	95.66%	96.27%	96.44%	96.13%
	AMI Beta Blocker at Arrival	90.47%	94.44%	95.21%	93.28%
	AMI Beta Blocker Prescribed at Discharge	93.82%	95.97%	97.20%	95.68%
	AMI Primary Percutaneous Coronary Intervention Received Within 120 Minutes of Hospital Arrival	/0	65.14%	75.61%	72.13%
	AMI Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival	/0	44.44%	22.22%	29.63%
	AMI Class	**93.50%**	**95.05%**	**95.76%**	**94.81%**
Heart Failure Class	Heart Failure ACEI or ARB for LVSD	87.81%	90.42%	92.92%	90.28%
	Heart Failure Adult Smoking Cessation Advice/Counseling	/0	95.63%	96.09%	95.93%
	Heart Failure Discharge Instructions	/0	70.29%	78.48%	75.76%
	Heart Failure LVF Assessment	90.48%	93.86%	93.12%	92.45%
	Heart Failure Class	**89.66%**	**88.41%**	**88.42%**	**88.73%**
Pneumonia Class	Pneumonia Adult Smoking Cessation Advice/Counseling	/0	93.46%	94.31%	94.10%
	Pneumonia Appropriate Initial Antibiotic Selection	/0	86.92%	90.19%	89.32%
	Pneumonia Blood Culture Performed in Emergency Department Before First Antibiotic Received in Hospital	/0	91.03%	90.78%	90.84%
	Pneumonia Influenza Vaccination Status	/0	76.06%	86.05%	82.78%
	Pneumonia Initial Antibiotic Received Within 4 Hours of Hospital Arrival	71.06%	78.63%	84.06%	77.62%
	...genation Assessm...		...9.67%	99.60%	...

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Member Reports: Individual and Comparative

Knee Replacement

Hip Replacement

AHRQ PSI # 12 Drill-Through Report for Hospital A

Unique ID per Discharge	Patient Zip Code	Age Description	Gender	Mortality	Length of Stay	TOTALCHG	Attending ID - Name	Operating ID - Name	Product Line
13841420	XXXXX	80-84 Years	Female	0	29	$244,586	M1573 -	K4550 -	Orthopedics
13841616	XXXXX	80-84 Years	Female	0	30	$538,029	J3159 -	G5202 -	General Surgery
13842357	XXXXX	85-89 Years	Male	1	15	$270,789	M1573 -	G5202 -	General Surgery
13843036	XXXXX	60-64 Years	Female	0	4	$80,591	M5039 -	L8992 -	Vascular Surgery
13843091	XXXXX	55-59 Years	Female	0	7	$162,054	M1573 -	K3777 -	General Surgery
13843474	XXXXX	75-79 Years	Male	0	28	$208,308	E0841 -	H5857 -	General Surgery

DRG Expanded	APRDRG Expanded	Severity Score - Description	Primary Pay	Acquired Immune Deficiency Syndrome	Alcohol Abuse
480 - Hip & femur procedures except major joint w MCC	308-Hip & Femur Procedures for Trauma Except Joint Replacement	4-Extreme	Unknown	0	1
003 - ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	004-Tracheostomy w/ Long Term Mechanical Ventilation w/ Extensive Procedure	4-Extreme	Medicare Part A	0	0
414 - Cholecystectomy except by laparoscope w/o c.d.e. w MCC	262-Cholecystectomy Except Laparoscopic	4-Extreme	Unknown	0	0
252 - Other vascular procedures w MCC	173-Other Vascular Procedures	3-Major	Medicare Part A	0	1
003 - ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	005-Tracheostomy w/ Long Term Mechanical Ventilation w/o Extensive Procedure	4-Extreme	Medicare Part A	0	0
853 - Infectious & parasitic diseases w O.R. procedure w MCC	720-Septicemia & Disseminated Infections	4-Extreme	Medicare Part A	0	0

PRINDIAG	DIAG2	DIAG3	DIAG4	DIAG5	DIAG6	DIAG7	DIAG8	DIAG9	DIAG10	DIAG11	DIAG12	DIAG13	DIAG14	DIAG15	DIAG16	DIAG17	DIAG18	DIAG19	DIAG20	DIAG21	DIAG22	DIAG23	DIAG24	DIAG25	PRINPROC	PROC2	PROC3
820.8	518.81	205.00	284.1	584.9	585.4	276.2	599.0	453.42	999.8	403.90	285.21	564.00	443.9	276.7											79.35	38.7	41.31
998.59	569.83	552.20	518.81	276.3	276.1	453.8	599.0	263.9	280.0	401.9	427.31	429.3	276.8	244.9											86.22	31.1	45.76
574.80	410.91	453.42	491.21	263.9	782.4	428.30	998.2	799.02	401.9	427.31	780.09	427.9	576.8	276.8											51.22	87.53	44.61
442.3	585.6	453.41	403.91	250.40	599.0	964.2	571.8	285.21																	39.50	00.55	00.45
038.10	348.31	785.52	585.4	276.2	682.7	682.6	584.9	599.0	428.22	518.81	997.62	453.9	995.92	443.9											86.22	31.1	86.22
038.0	707.03	204.10	707.09	728.88	415.19	263.9	507.0	511.9																	33.27	33.24	86.28

Hip Replacement Counts with Complication Rates by Hospital and Physician 2007Q4 – 2008Q3

Discharge Quarter	Participating Hospital	Attending Physician ID	Attending Name - ID	Unique ID per Discharge	Case Count	DVT Count	DVT Rate
2008Q3	Hospital X	12345	Jane Doe - 12345	14439531	1	0	0.0%
						0	0.0%
				14441130	1	0	0.0%
			John Doe - 67890		3	1	33.3%
		67890			3	1	33.3%
		14982	Doctor Smith - 14982	14439893	1	0	0.0%
				14440610	1	0	0.0%
			Doctor Smith - 14982		2	0	0.0%
		14982			2	0	0.0%
		54321	Doctor Jones - 54321	14438802	1	0	0.0%
				14440111	1	0	0.0%
				14440396	1	0	0.0%
			Doctor Jones - 54321		3	0	0.0%
		54321			3	0	0.0%
	Hospital X				27	1	3.7%
			Doctor Bob - 80802	14567747	1	0	0.0%
			Doctor Bob - 80802		1	0	0.0%
					1	0	0.0%
		19125	Doctor XX - 19125	14567753	1	0	0.0%
			Doctor XX - 19125		1	0	0.0%
		19125			1	0	0.0%
		00552	Doctor XXX - 00552	14567735	1	0	0.0%
				14568008	1	0	0.0%
			Doctor XXX - 00552		2	0	0.0%
		00552			2	0	0.0%
	Hospital Y				4	0	0.0%
2008Q3					1,399	12	0.9%
Summary					5,687	49	0.9%

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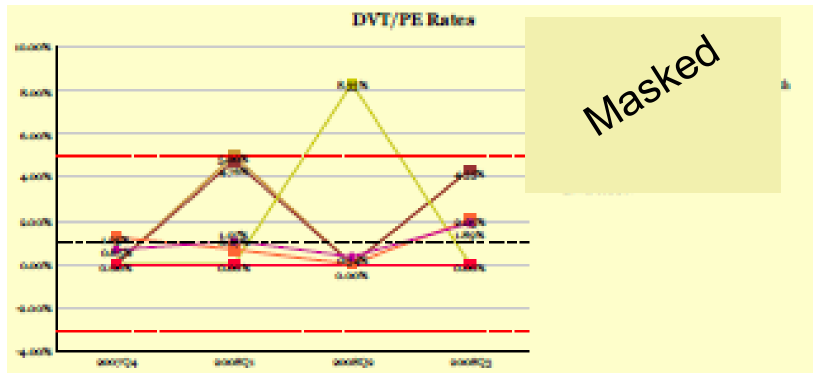
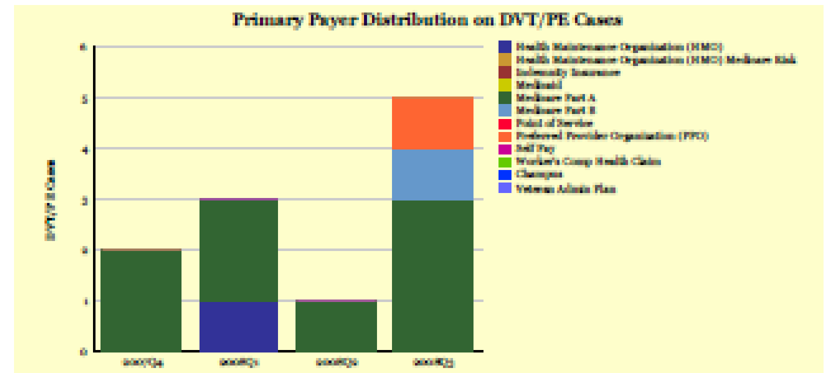
Member Dashboards: System- and Hospital-Level

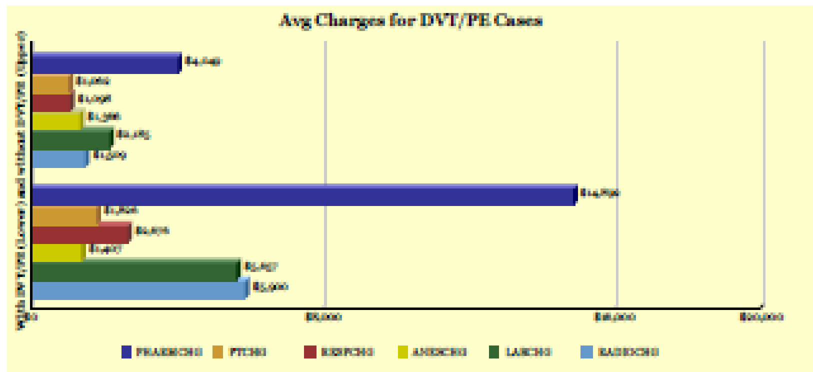
Hip Replacement

Hip Replacement Procedure Dashboard for Health Care System XYZ and One Hospital

Deep Vein Thrombosis and Pulmonary Embolism Cases from Hip Replacement Procedures







Operating Physicians with DVT/PE Cases

	Cases				Case Total
	2007Q4	2008Q1	2008Q2	2008Q3	
	1			1	2
	1			1	2
		1			1
		1			1
		1			1
			1		1
				1	1
				1	1
				1	1
Hospital Total	2	3	1	5	11

Year/Quarters: 2007Q4, 2008Q1, 2008Q2, 2008Q3

Rate Numerator: 415.11 Iatrogenic pulmonary embolism and infarction, 415.19 Other, 453.40-453.42 Venous embolism and thrombosis of deep vessels of distal lower extremity
Rate Denominator: 81.51 Total hip replacement, 81.52 Partial hip replacement, 81.54 Total knee replacement

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Regional Enterprise Master Patient Index

Hip Replacement Admissions and Readmission Characteristics

Readmit Status of Total Hip Replacement with DVT Complication

Total Hip Replacement Patient w/ Complications -- Admit History

Unique ID per Discharge	REMPI	Participating Hospital	ReAdmit Facility	Admission Date	LOS	ReAdmit Date	PRINDIAG	Diagnosis Description	DIAG2
13131313	7654321	Hospital A	Hospital A	2008-02-21	5	06/25/2008	V57.89	OTH REHABILITATION	V45.4
14141414	7654321	Hospital A		2008-06-25	8	No ReAdmit	715.35	LOCALIZED OSTEOARTH UNSPEC PELVIS	453.41

Principal Diagnosis

Admitted for total hip replacement procedure

Diagnosis Position 2: 453.41
Venous embolism and thrombosis of deep vessels of proximal lower extremity

First admission in Regional Enterprise Master Patient Index

V57.89 = Other specified rehabilitation procedure, multiple training or therapy

Readmit Status of Total Hip Replacement without Complication(s)

Total Hip Replacement Patient w/o Complications -- Admit History							
Unique ID	REMPI	ReAdmit Facility	Admission Date	PRINDIAG	Diagnosis Description	ReAdmission Day Group	Date of Death
11111111	1234567	Hospital A	2004-06-05	965.09	POISON OPIATES OTH	0-30 Days	
22222222	1234567	Hospital A	2004-06-05	296.33	RECURR MAJOR DEPRESSIVE SEVERE	0-30 Days	
33333333	1234567	Hospital B	2004-06-06	296.33	RECURR MAJOR DEPRESSIVE SEVERE	Over 90 Days	
33333333	1234567	Hospital B	2004-09-14	486.	PNEUMONIA ORGANISM UNSPEC	0-30 Days	
44444444	1234567	Hospital B	2004-10-13	486.	PNEUMONIA ORGANISM UNSPEC	61-90 Days	
55555555	1234567	Hospital B	2004-12-30	486.	PNEUMONIA ORGANISM UNSPEC	Over 90 Days	
66666666	1234567	Hospital B	2005-06-23	965.4	POISON AROM ANALGESICS OTH	Over 90 Days	
77777777	1234567	Hospital B	2005-10-12	969.0	POISON ANTIDEPRESSANT	Over 90 Days	
88888888	1234567	Hospital B	2006-12-30	682.6	CELLULITIS/ABSCESS LEG	31-60 Days	
99999999	1234567	Hospital B	2007-02-15	486.	PNEUMONIA ORGANISM UNSPEC	Over 90 Days	
10101010	1234567	Hospital B	2008-08-25	733.42	ASEPTIC NECROSIS HEAD & NECK FEMUR	0-30 Days	
12121212	1234567		2008-09-09	682.6	CELLULITIS/ABSCESS LEG	No ReAdmit	

Less than 30 Days Since Last Admission

Total Hip Replacement

Not readmitted as of 2008Q3

Not deceased

DFWHC
Education and
Research
Foundation

Patient Safety & Quality Committee

Regionally-based Collaboration

Patient Safety & Quality Committee

- The Foundation's Patient Safety & Quality Committee (PSQC) was founded with the purpose of ***improving the health care of the communities served through the effective use of healthcare data.***
- The PSQC is comprised of 13 professionals with the following expertise:
  - Quality Improvement
  - Patient Safety
  - Infection Control
  - Data Analysis
  - Clinicians
  - Pharmacy
- Committee membership is by invitation only and members serve staggered two year terms.

PSQC history with analyzing AHRQ Quality Indicators

- 2007: Focused on getting acquainted with the quality indicators
  – Various ways to look at the information (tables, charts, red light/green light, etc.)
  – Regional trends in AHRQ IQI's and AHRQ PSI's
- 2008 and 2009: Focused on examining specific indicators at the hospital level and sharing lessons learned

Committee's general process for working with CMS and AHRQ QIs

- Review annual and quarterly quality indicator data
- Decide on a process for discussing and sharing information in terms of quality improvement considering:
  - Trends and variation in the data
  - Relevant guidelines or policy implications associated with that indicator or the larger disease state/process

Example 1: AMI Mortality (AHRQ IQI #15)

Number of Deaths per 100 Discharges with a Principal Diagnosis Code of AMI

Risk Adjusted Rate

12.4
11.4
10.4
9.4
8.4
7.4
6.4
5.4
4.4

UCL=10.96
Avg=9.14
LCL=7.32

00 01 02 03 04 05 06 07 08

2000 - 2008

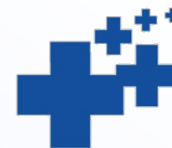
Example 1: AMI Mortality (AHRQ IQI #15)

- Based on positive regional trends, focused on contacting a select subset of hospitals for interview
- Goal was to determine if indicator performance was associated with the implementation of any specific process, protocols, etc.
- Committee collectively identified set of relevant questions
- Two volunteers interviewed six selected facilities and subsequently shared results with the larger group

Example 1: AMI Mortality (AHRQ IQI #15)

- Themes shared as result of interviews:
  - Clear focus on door to balloon time
    - Early notification by Emergency Medical Services (EMS) of the cardiac team
    - Use of standardized protocols and ED algorithms
  - Presence of a dedicated team tracking and monitoring the acute myocardial infarction (AMI) patient
  - Monitoring emphasis on the AMI portion of the core measure set (not the IQI)

Example 2: Post-Op DVT/PE (AHRQ PSI #12)



Cases of DVT or PE per 1,000 Surgical Discharges with an Operating Room Procedure.

DFWHC ERF 2009

Example 2 : Post-Op DVT/PE (AHRQ PSI #12)

- Based on the indicator's negative trends for the region and the majority of hospitals, we decided to use a multi-pronged approach for engaging hospitals on this issue.
  - Kicked off activities with an educational forum in late March 2009.
    - National content experts on deep vein thrombosis (DVT) awareness and changes to venous thromboembolism (VTE) quality measures and reimbursement policies.
    - Local panel discussion involving hospitals and home care
    - Demonstration to audience of the QI data and the analysis tools available to assist them as they work on this issue.

Example 2 : Post-Op DVT/PE (AHRQ PSI #12)

- Launched a survey in mid-April to assess for themes regarding the region's approach to VTE prophylaxis
  - Different approach than the AMI example
    - Made survey available to all interested hospitals
    - Used a structured online survey based on detailed literature review and validation by content experts
  - After completing analysis, will communicate results via multiple venues (committee meetings, forums, newsletters)
- Pursuing resources to conduct a detailed analysis of the clinical and financial outcomes of hospitals with comprehensive VTE risk assessment programs

Important Points

- AHRQ QI's not necessarily widely understood or heavily monitored by hospitals
- There is no set way to engage hospitals in using the quality indicators as part of quality improvement activities
- Be flexible

Contacts

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Questions

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Agenda

- Welcome and Introduction
- Quality Improvement Overview
- Questions and Answers
- Dallas-Fort Worth Hospital Council Example
- Questions and Answers
- Pacific Business Group on Health Example
- Questions and Discussion

California Quality Collaborative (CQC)

Multi-stakeholder collaborative (plans, purchasers, providers and partners) staffed by Pacific Business Group on Health (PBGH) to accelerate measurable improvement

Outline

- Get oriented
- Why do QI?
- How we do QI : Some case studies
  - What we gained
  - What we learned
- Overall program participation and funding

	Hospital	Physician Group	Physician
1. Collect Standardized Data	CA Hospital Assessment and Reporting Task Force	Integrated Healthcare Association	PBGH
2. Reward Performance		6 HMO Insurance Plans	
3. Publicly Report	www.calhospitalcompare.org Began 2007	www.opa.ca.gov Began 2004 200 doctor groups	
4. Improvement Support		CQC	CQC

California Public Report Card

State of California - Health Care Quality Report Card - Windows Internet Explorer

http://www.opa.ca.gov/report_card/medicalgrouprating.aspx

Health Plans | Doctors and Medical Groups | Hospitals and Long-Term Care | Language Services | Research and Background

Page tools

- Print this chart
- Print all Medical Group Ratings charts for Alameda County

Related links

- About the Medical Group Ratings
- What Is a Medical Group?
- How to Choose a Medical Group
- California Association of Physician Groups (CAPG)
- Integrated Healthcare Association (IHA)
  - IHA Top Rated Medical Groups

Doctors and Medical Groups ▸

Medical Group Ratings At-a-Glance

Alameda

Choose a different county

★★★★ Excellent
★★★ Good
★★ Fair
★ Poor

	Meeting National Standards of Care	Patients Rate Medical Groups
Affinity Medical Group	★★★★	★★★
Alta Bates Medical Group	★★★	★★★
Bay Valley Medical Group, Inc.	★★	★★★
Hill Physicians Medical Group - East Bay	★★★	★★★
John Muir Physician Network	★★★	★★★
Kaiser Permanente Medical Group - Diablo Service Area	★★★★	★★★
Kaiser Permanente Medical Group - East Bay Service Area	★★★★	★★★

Meeting National Standards of Care

We compared each medical group's patient records to a set of national standards for quality of care.

- Asthma Medicine
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Child Immunizations
- Chlamydia Screening
- Testing Cholesterol for Heart Patients
- Controlling Cholesterol for Heart Patients
- Testing Cholesterol for Diabetes Patients
- Controlling Cholesterol for Diabetes Patients
- Testing Blood Sugar for Diabetes Patients
- Controlling Blood Sugar for Diabetes Patients
- Testing Kidney Function for Diabetes Patients
- Treating Children with Upper

Publicly Reported Measures

Clinical Quality

- Mostly HEDIS-based measures on preventive and chronic care

Patient Experience

- Collected through common statewide CAHPS-like survey

Investment and Adoption of IT

- Audited self-report

Resource Use

- Utilization (ED use, generic RX, readmissions), testing total cost of care and episode-based metrics

Why Do QI?

- Changes the political dynamic
  - Walk the Improvement Talk: Builds trust with those in public report and creates more support from those sponsoring reporting (plans, purchasers)
- Results: 1+1 = 3
  - Cases where reporting plus QI get better results than either alone
- It's fun and can be cheap

CQC Offerings 2008 - 2009

1. Implementation Collaboratives – 12 month programs for Improvement Teams
    1. Improving Patient Satisfaction Scores
    2. Improving Clinical Metrics
    3. Improving Efficiency/Total Cost
2. Regional Learning Networks – Free
    - Quarterly half-day sessions in local areas
3. Learning Exchanges - Free
    - One-day conferences on specific topics
4. One-day Skill Building Sessions – Minimal fee
    - Engaging Physicians in Change
    - ABCs of QI
    - Data Analysis and Project Management
    - Leadership Development

Improvement Support Options:

"One and Done"

1. Encourage Exchange of Effective Practices Across Organizations
   - One-day conferences, teleconferences
2. Document Better Practices
   - Catalogue most effective strategies and tools
     www.calquality.org/documents/CQC-IPE-QuickReferenceGuide.pdf

On-going or Time Limited Programs

3. Build Learning Networks
   - Quarterly meetings for peers
4. Provide Implementation Support
   - Year-long training and coaching

Encouraging Peer-to-Peer Learning for "One and Done"

	Traditional Conference	Encouraging Exchange of Effective Practices
Speakers	Famous individuals	Highest local performers, or those who are most improved
Agenda design	Fill time with good speakers	Plan 50% of time for speakers. 50% facilitated discussion/Q&A.
Audience role	Listens and takes notes	Actively solicit other good ideas from audience, capture for all
Materials	Presentations	Ideas and tool summary

Case: Improving care in small and medium physician groups
www.calquality.org/documents/LAOC_Dec2_Agenda_final.doc

Build Learning Network Case: Inland Empire

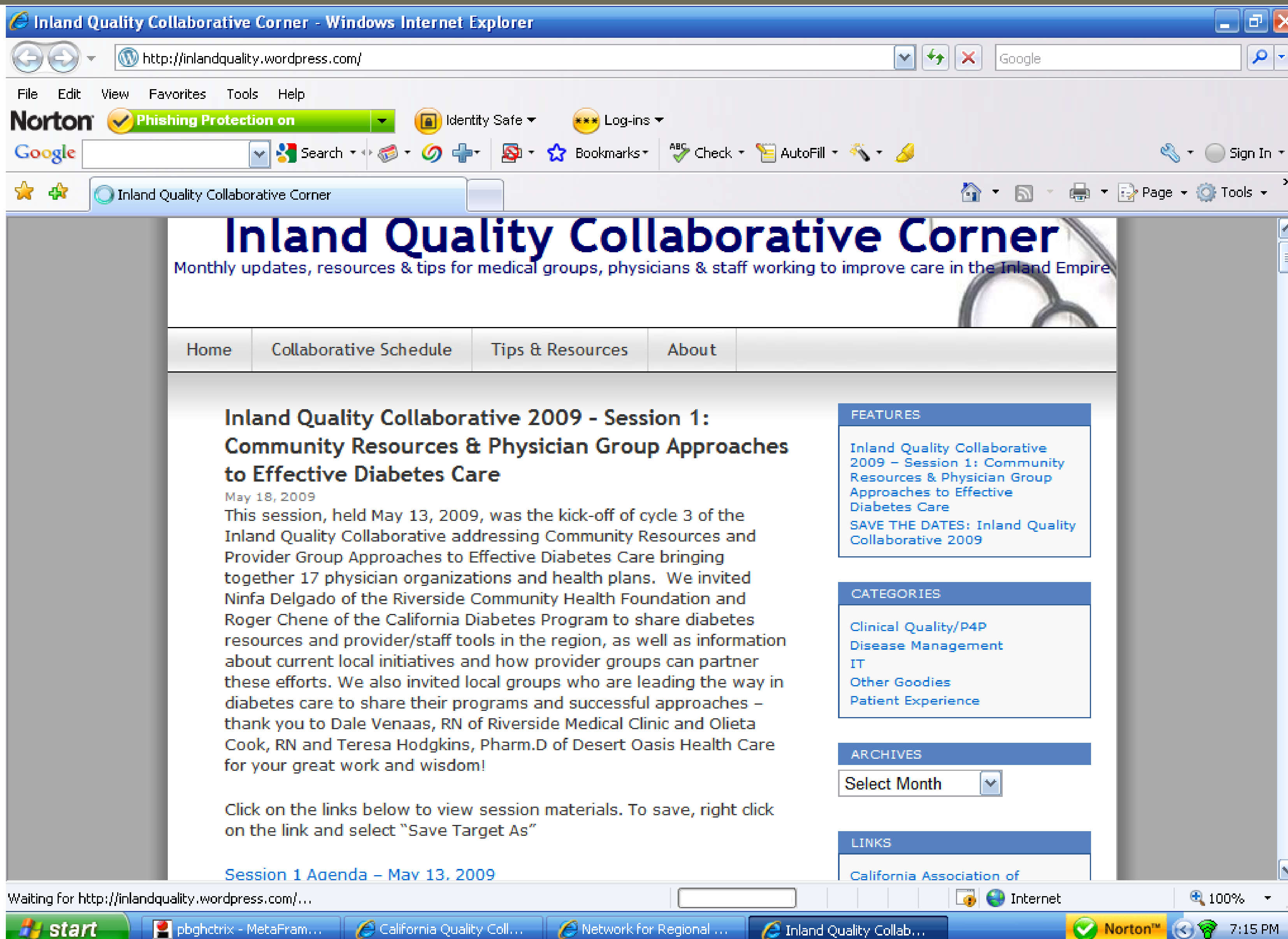
- First meeting April 2007 included regional results (Lowest in the State)
- Quarterly on-sites, monthly teleconferences, newsletter
- 3-4 hour meetings following local provider association meeting on participant-driven improvement topics – most presenters local
- CQC facilitated planning group of providers, plans and others
- Resources: <.2 FTE plus meeting expenses

What Happened

- 23 out of 45 physician groups in the area participated over 12 months (35 – 60 people at quarterly on-site meetings)
- Publicly reported clinical results for participating organizations improve more than non-participants
- Other organizations in region joined
  - Local foundation, community groups, public hospitals, community clinics, etc.
- Reported and reporters very happy

Some Useful Learning Network Techniques

- Start with a launch conference
- Quarterly meetings 3-4 hours (lunch!)
- Every organization talks – go round at early meetings
- 3 brief presentations from network “members” to start discussion. No more than 50% presentation. “Tips” sent via newsletter.
- Blog newsletter http://inlandquality.wordpress.com
- Separate CEO dinner session
- Separate QI skills training
- Annual community conference draws new individuals and new organizations


Inland Quality Collaborative Corner - Windows Internet Explorer
http://inlandquality.wordpress.com/
Inland Quality Collaborative Corner
Monthly updates, resources & tips for medical groups, physicians & staff working to improve care in the Inland Empire
Home
Collaborative Schedule
Tips & Resources
About
Inland Quality Collaborative 2009 - Session 1: Community Resources & Physician Group Approaches to Effective Diabetes Care
May 18, 2009
This session, held May 13, 2009, was the kick-off of cycle 3 of the Inland Quality Collaborative addressing Community Resources and Provider Group Approaches to Effective Diabetes Care bringing together 17 physician organizations and health plans. We invited Ninfa Delgado of the Riverside Community Health Foundation and Roger Chene of the California Diabetes Program to share diabetes resources and provider/staff tools in the region, as well as information about current local initiatives and how provider groups can partner these efforts. We also invited local groups who are leading the way in diabetes care to share their programs and successful approaches – thank you to Dale Venaas, RN of Riverside Medical Clinic and Olieta Cook, RN and Teresa Hodgkins, Pharm.D of Desert Oasis Health Care for your great work and wisdom!
Click on the links below to view session materials. To save, right click on the link and select "Save Target As"
Session 1 Agenda – May 13, 2009
FEATURES
Inland Quality Collaborative 2009 – Session 1: Community Resources & Physician Group Approaches to Effective Diabetes Care
SAVE THE DATES: Inland Quality Collaborative 2009
CATEGORIES
Clinical Quality/P4P
Disease Management
IT
Other Goodies
Patient Experience
ARCHIVES
Select Month
LINKS
California Association of

Provide Implementation Support Case: Patient Experience

Summary: CQC Patient Experience Collaborative 2006 - 2007
Performance on Patient Experience P4P Metrics: 2007 - 2008
Relative Change from 2007 - 2008

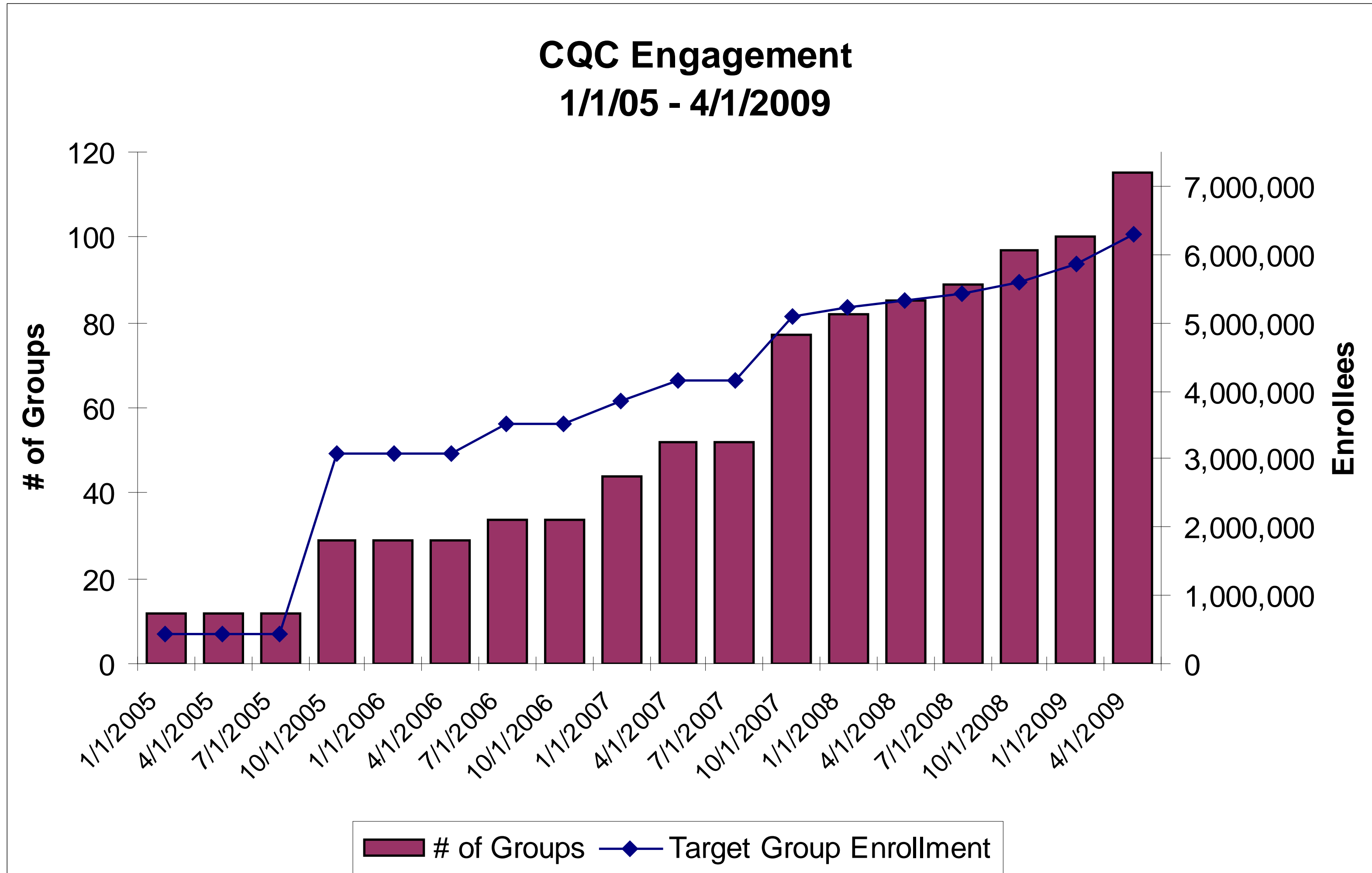
P4P Domain	Statewide	CQC Pt. Exp. Collab Participants
# groups	192	4
Rating of All Care	**3.00%**	**7.60%**
Rating of PCP	**1.10%**	**1.90%**
Rating of Specialist	**-0.20%**	**7.10%**
Access	**0.70%**	**1.60%**
MD Interaction	**0.10%**	**11.10%**
Coordination of Care	**0.40%**	**6.80%**
Office Staff	**0.40%**	**1.60%**

Participants: Affinity Medical Group, Greater Newport Physicians
John Muir Health Network, Monarch Healthcare

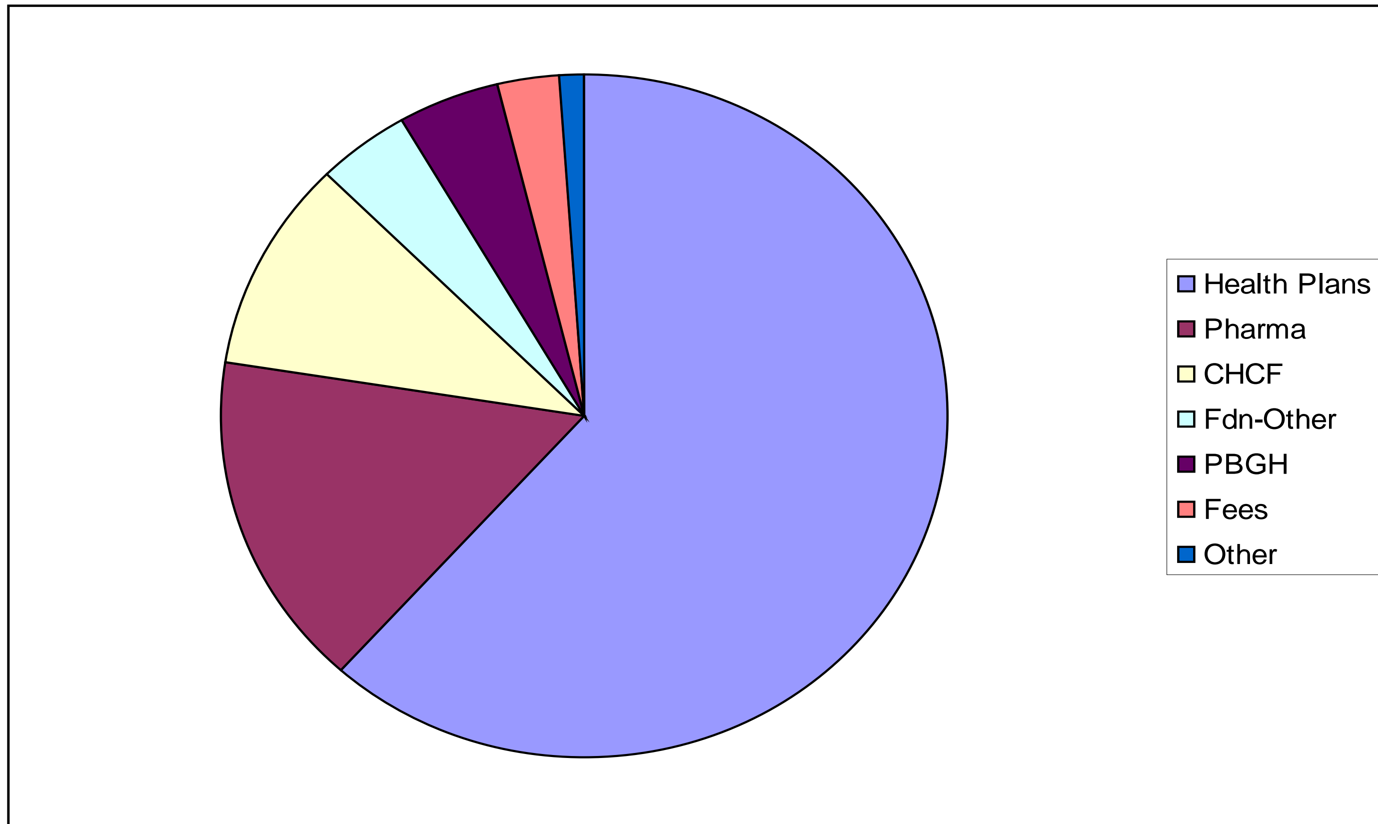
Some Tips for Facilitating Peer-to-Peer Learning…

1. Content must be built around “self-identified peers” (regional focus, job type)
2. If possible, attach to existing meeting/organization (e.g., Hospital Association)
3. Use multi-stakeholder planning committee to design content, including “customers”
4. Learning vs. Teaching: Limit outside expert presentations, unless invited by attendees
   - Focus on showcasing best practices within peers
5. Audience wants to hear “How” from implementers themselves

Engagement in Change



Funding
$1.2 Million or $.03/Resident



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Next Web Forum

Question and Answer Web Forum

August 12, 2009, at 1:00 p.m. ET

John Bott, Center for Delivery, Organization, and Markets, AHRQ

Mamatha Pancholi, Center for Delivery, Organization, and Markets, AHRQ

Jeff Geppert, Battelle Memorial Institute (QI Developer)

You are welcome to invite others from your organization

For More Information

- QI Learning Institute Web Forum: https://ahrqqili.webexone.com/

  Login Name: First letter of first name followed by last name; capitalize first two letters (Example: JBott).

  If you forgot your password, enter your Login Name and press "Forgot your password?" and Webex will e-mail you a temporary password.

- QI Learning Institute E-Mail: QualityIndicatorsLearning@ahrq.hhs.gov
- QI Web Site: http://www.qualityindicators.ahrq.gov/
- QI Support E-Mail: support@qualityindicators.ahrq.gov

QILI Evaluation

- Please fill out the evaluation form that will pop up on your screen after you leave the Web conference.
  - The first two questions are about today's Web conference.
  - The remaining questions are about the QI Learning Institute in general.
- We will incorporate all your feedback into the next contract, which we anticipate to be a similar learning network that will provide education and training on how to use MONAHRQ (previously named EQUIPS) for reporting initiatives. All current QILI members will be invited to join this new project.
- We appreciate your feedback. Thank you for your participation!

Today’s Learning Objectives

- Raise awareness of the opportunity to work on quality improvement with hospitals that appear in your public report
- Understand hospitals’ capacities to engage in quality improvement related to areas measured in your report
- Once a public report card is in place, understand strategies used by others to foster the spread of best practices among providers
- Learn from case examples the cost/benefit associated with strategies for facilitating peer-to-peer learning