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The Quality Post

Monthly Quality Improvement Newsletter
FOR THE
Division of Hospital Medicine

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Greetings from Michelle & Katie

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the sixth issue of the Quality Post. Value is everywhere in the news these days, and after a recent Grand Rounds, we thought we'd explore what Value means for health care, and for Medicare's new Value Based Purchasing Program. We'll also update you on the new white boards audit plan and expectations for use, along with our usual features QI Committee Updates and Division Incentive Metric Updates.

The Value Equation

Current healthcare reform legislation is largely focused on the shift from paying for volume to paying for **value**. But what is ***value*** in healthcare, why is it important, and how do we achieve it?

Value, simply defined, is ***health outcomes achieved per dollar spent*** or ***quality/cost***. Achieving value is emerging as a concept that all can embrace: providers, patients, payers and policy makers. As described by Lee in a recent NEJM article, no one argues against "the goal of improving outcomes and doing so as efficiently as possible" and expect long term success.

To achieve value, we must start by establishing a measurement strategy that focuses on **outcome** over **process** measures, and one that focuses on those outcomes that matter to patients.

There is also a shift in what is meant by costs, which should now include costs over a patient's entire cycle of care, rather than for a particular hospital or clinic. This is a big mental switch for physicians who like to think of themselves as bystanders in the We must look for ways in which we can eliminate non-value added services, better use capacity by improving patient flow, and create leaner processes in our day to day work. For strategies and musings on what it will take to cut costs, see Bob's excellent recent blog post.

Medicare's Value Based Purchasing: The Basics

CLINICAL METRICS

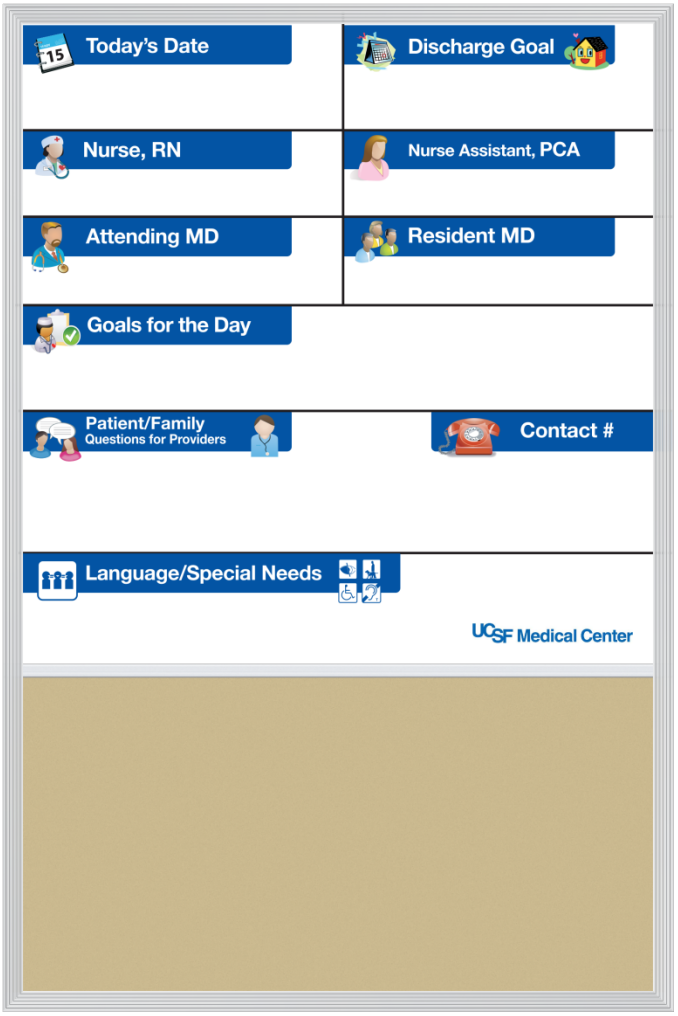
There are 17 clinical metrics under CMS's Clinical Process of Care heading. CMS will use hospital data to calculate a performance score ranging from 0 to 10. A hospital earns an achievement score based on performance relative to other hospitals, and an improvement score based on whether it beat its own past performance. In theory, a hospital could receive all 10 points if it beats the achievement benchmark, or 0 if it fails to meet the achievement threshold or better its own previous score.

PATIENT STATISFACTION MEASURES

For the eight measures based on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient surveys, the scoring is roughly the same. The measures look at patient's satisfaction with nursing, physician and overall hospital performance.

For the fiscal year 2013 evaluation period, HCAHPS scores will count 30% toward the final score, while the Clinical Process of Care scores will be weighted 70% toward the score.
Hospitals will receive a percentage grade based on how many points they scored out of the possible total.

CMS will post all scores on its Hospital Compare site and use the final performance score to determine the incentive payment. For more information check out this article in The Hospitalist



The New White Boards are Here!

And we wanted to provide you some easy tips for their use:

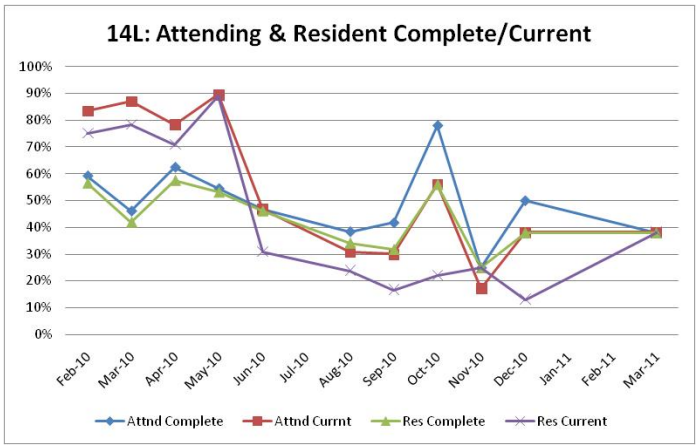
Why should you care about the standardized whiteboards?
Improving patient satisfaction is an important and ongoing Medical Center and Divisional goal. Ensuring that patients are aware of their providers, plan for the day, and discharge goals are all important to achieving top notch patient satisfaction scores, and the standardized whiteboard has been shown to improve patient awareness of these metrics.

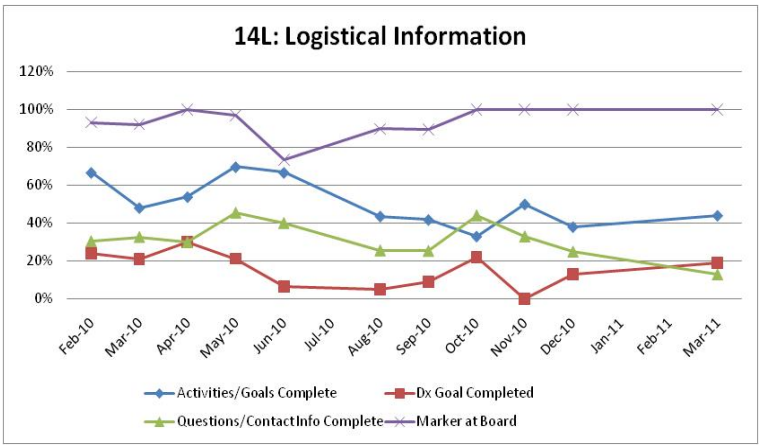
What elements of the standardized whiteboard am I and my medical team responsible for?
1) **Write your name** on the board as you introduce yourself to the patient.
2) **Write any plans/tests/goals** for the day.
3) **Write discharge goal**.
4) **Address any patient/family concerns** written on the board.

How can I ensure that my team uses the whiteboards?
1) **Make it an expectation** that your team regularly utilizes and updates the whiteboards. In fact, if you take the lead and start writing on the whiteboards, our audit data suggests that the rest of your team will follow.
2) Have the housestaff **standardize a time** that they will utilize/update the whiteboard (i.e. during pre-rounds, during rounds with the team).
3) Although templated whiteboards are not up yet throughout the hospital, make this **something that you do for every patient on every floor.** These newer, bigger, templated whiteboards are in the works throughout the hospital.

Are You Communicating with Nurses, Patients and Families?

One of our QI themes for this year is "**Communication**." Communication with nurses, patients, PCPs, consultants and during handoffs. White boards are a great way to communicate simultaneously with nurses and patients on goals for the day, discharge goals and questions from family. As the white boards go up on 14L and 14M, look for increasing emphasis and feedback on our performance.





QI Committee Take-Aways

Publically Reported Data: (Hospital Aquired Infections and Mortalty) presented in May, along with some Visioning for our Division Incentive Metrics for 2012… Coming soon!

Publically reported Data

Hospital Aquired Infections: The trend is UP, we'll contine to monitor

- C-Diff and CRBSI rates doubled over the past quarter. These were non-significant increases and drill-down revealed limited preventability.

Indicator	Target	Stretch	CY 2010	Q3 2010	Q4 2010	Q1 2011	Q2 2011	YTD
Hospital Acquired Conditions								
HAC: C-diff rates (%)	0.5	0.25	13 (0.32%)	**4 (.34%)**	**4 (.31%)**	**9 (.70%)**		**17 (.45%)**
CVC Infections (CRBSI)	<2	0	6	**1**	**2**	**5**		**8**

Mortality Analysis: Looking at Expected vs. Unexpected Deaths

Summary of 2010 deaths	Total	Deaths	Expected	Unexpected
Cases	4,603	247	183 (74%)	64 (26%)
LOS Outliers	(94)	(7)	4	3
Mean LOS (Obs)	6	9	9	12
Mean LOS (Exp)	5.98	9.75	10.13	8.66
LOS Index	1	0.97	0.89	1.39
% ICU Cases	17.27	57.89	59.56	53.13
Palliative Care (by coding)		80 (32%)	56 (31%)	24 (38%)
DNR Coded		11	9	2

- Mortality ratios, comparing expected deaths to unexpected deaths based on patient severity are the most common way for understanding mortality.
- Katie and Michelle presented findings from CY 2010 mortality analysis. Mortality for pneumonia and sepsis are on target with a mortality ratio <1
- Overall there were 64 *unexpected* deaths on the Medicine service in 2010. We will begin analyzing unexpected deaths to look for trends in quality of care, documentation or coding.

Actions:

- No changes currently currently recommended for faculty regarding hospital acquired infections, continue excellent Hand Hygiene Practices
- As deaths are often "unexpected" due to documentation and coding that does not reflect patient severity, we may provide faculty with recommendations on documenting illness severity.

FY 2012 Planning: Communication and Preventibility

QI Committee

- The QI committee spent time reflecting on what worked well and what could have improved in the way the committee functions and evaluates and improves on Divisional Quality metrics. ***If you have any feedback on our work thus far, please contact either Michelle or Katie directly.***

Division Incentive Metrics 2012: Communication and Preventability

- The committee also started brainstorming potential Division Incentive Metrics for FY2012.
- Metrics will focus on our two goals for 2012, Communicaiton (Handoffs, Whiteboards, Patient Satisfaction) and Preventibility (Sepsis, Readmissions, HA Infections, Hand Hygiene). These will be finalized during the June meeting and disseminated to the Division in the next QI newsletter.

Division Incentives Update

Division Incentive Goal	Progress towards Goal	Baseline Data	FY 2011
Decrease average time to attending signature of discharge summaries to <2days from DC.	⊙	Average time to attending signature for CY 2010: 5.8 days	4 of 6 recent months

Dec	Jan	Feb	March	April	May
1.87	**1.34**	**1.35**	**1.66**	**1.72**	**1.56**

Maintain 30 day overall readmission rates <15% for patients >65.	→	**Readmission Rates:** CY 2008: **16.5%** CY 2009: **15.5%** CY 2010: **13.2%**	**4 of 6 recent months**

Dec	Jan	Feb	March	April	May
12.6	15.2	**13.2**	16.1	**10.6**	*Results Pending*

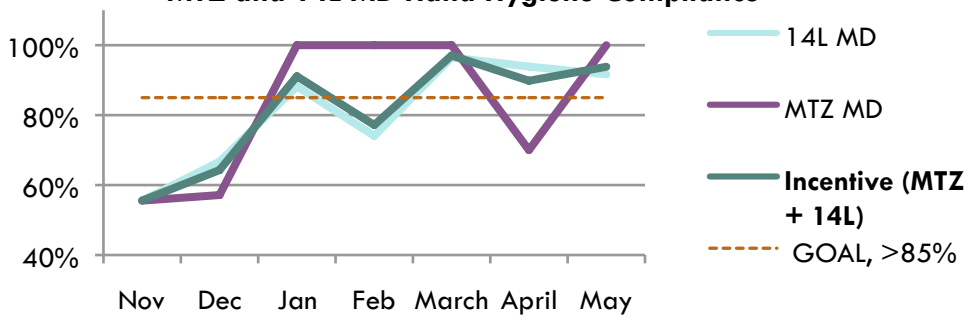
Maintain HCAHPS: Communication with Doctors Top Box score above 80%	⊙	**CY 2010 HCAHPS Top Box Score: 84%**	**4 of 6 recent months**

Nov	Dec	Jan	Feb	March	April
87%	**87%**	**92%**	61%	*75%*	**80%**

Improve MD hand hygiene rates to >85% on 14L	⊙	**2010 MD HH Compliance: 54%**	**4 of 6 recent months**

Dec	Jan	Feb	March	April	May
64%	**91%**	*77%*	**97%**	**90%**	**94%**

MTZ and 14L MD Hand Hygiene Compliance



⊙ = On target to achieve incentive goal, keep up the good work!

→ = Performance variable, continue known interventions: Timely follow up, Communication with PCP, and Assess for home care needs.

Calendar of Events

QI School

Break: Summer Break, will restart with Faculty Development in the Fall

Resident QI Lunches

M&M type format for Quality Cases:
June 17

Faculty QI Lunches

June 13: QI Potpourri updates
July 11: DHM Incentive Metrics

Center for Health Professions

July 13: Coaching Employees for Growth and Success
July 19: Practical Ways to Lead a (Less) Complicated Life