thequalitypost

in this issue

Monthly Quality Improvement Newsletter for the **Division of Hospital Medicine**

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Greetings from Michelle, Nader and Sasha

QUALITY IMPROVEMENT
DIVISION OF HOSPITAL MEDICINE

Welcome to the 47th edition of The Quality Post. In this issue we feature a piece on Sustaining the Gains in QI and highlights from our FY14 CPIC report. We also bring you data on our Division Incentive Metrics.

How do we sustain results from DHM improvement initiatives?

Sustaining improvement gains is one of the most challenging parts of a quality improvement intervention. In an ideal world, improvement efforts would change the care delivery system to ensure adherence to the newly designed process.

Classic teaching in sustainability stresses integrating the new process into daily work.

In reality however, improvement gains often result from a combination of changes to the system and:

1) Significant education about the problem and its impact of patient care
2) Audit and feedback of performance as a way to increase awareness about current performance.

Consider improved outcomes in hand hygiene, while placing dispensers outside every room helped integrate the new process into daily work, there is no "system change" to ensure ongoing adherence.

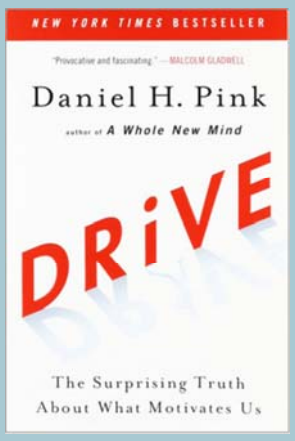
Or consider timely patient follow up appointments—while the process for making appointments can be made more easy and integrated into the work of discharge, this doesn't eliminate the need for education on the importance of follow up or our current performance.

To sustain improvement work the other facets of the improvement work must be sustained. Ask yourself:

1. Is there a knowledge gap about the importance of this process or outcome that must be sustained? How is this education built into the current curriculum?
2. Has the root cause of the status quo been adequately addressed? Or are barriers such as staffing, resources, knowledge, and competing priorities still present?
3. Where is current performance visible and how long is this *pushed* to participants before scaling back to participants knowing where to find the information?

DHM Book Club/Social Gathering

Nov 19, 5-8pm
Mellow Mellow Cafe



Cocktail Summary: Carrots & sticks are so last century. Drive says for 21st century work, we need to upgrade to:

Autonomy: the urge to direct our own lives.

Mastery: the desire to get better and better at something that matters.

Purpose: the yearning to do what we do in the service of something larger than ourselves.

We encourage you to read the book, but if you don't have time check out the author's Ted Talk: http://www.ted.com/talks/dan_pink_on_motivation

What National quality metrics are included in our CPIC report?

①What are the Reporting-Based Programs?

Starting in the early 2000s, the Joint Commission encouraged hospitals to voluntarily report on a set of core measures. In 2003 CMS and the Joint Commission created one common set of Core Measures, and tied reporting to payment. The most relevant metrics for hospitalists are the four pneumonia core measures.

②What are the CMS Performance-Based programs?

Percentages of Medicare DRG Payments are at risk from three major CMS hospital-based cost containing programs.

Hospital Readmissions Reduction Program (HRRP)

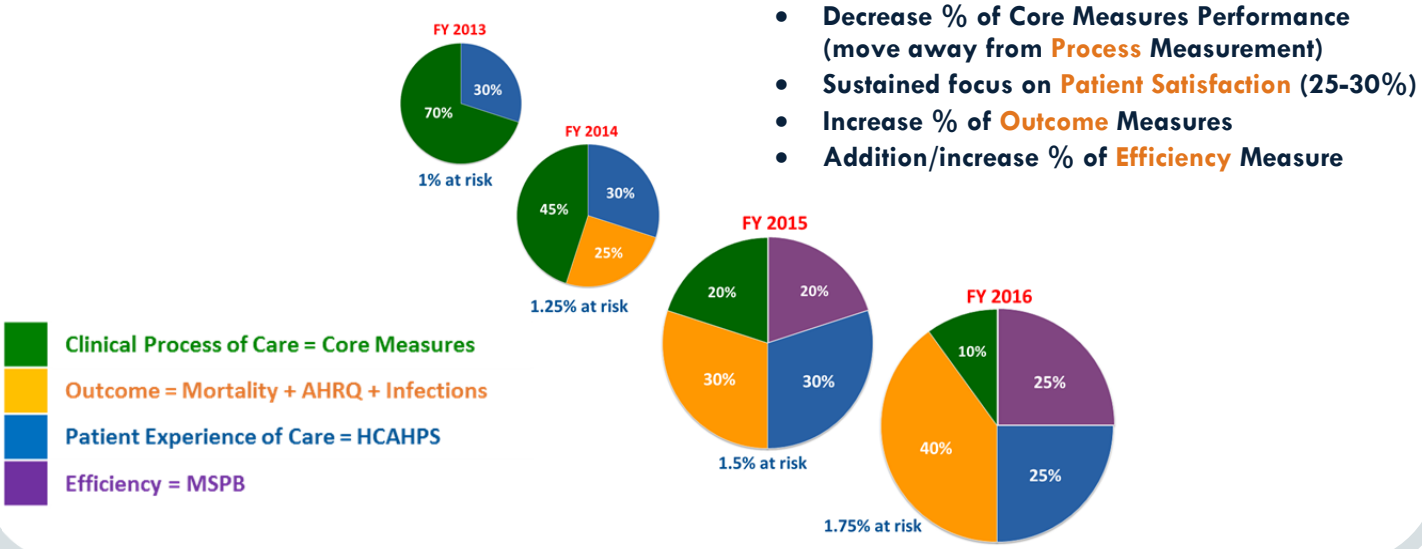
According to CMS, about one in five Medicare patients discharged from the hospital are readmitted within 30 days. Currently CMS imposes financial penalties to hospitals with excess readmissions for **AMI**, **HF**, **PN**, and have added the following for FY15: 1) patients admitted for an acute exacerbation of **COPD** and 2) patients admitted for elective total hip arthroplasty (**THA**) and total knee arthroplasty (**TKA**). Hospital penalties are then calculated as a payment reduction for *ALL MEDICARE* patients.

Hospital Acquired Conditions (HACs)

HACs are conditions that are 1) high cost or high volume or both, b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and c) could reasonably have been prevented through the application of evidence-based guidelines. To date there are 11 categories of HACs including Stage III and IV pressure ulcers, Catheter-Associated Urinary Tract Infections, Falls and Trauma to name a few.

Hospital Value-Based Purchasing (VBP)

In October 2012, Medicare began rewarding hospitals that provide high-quality care for patients through VBP. The program has 24 measures for FY 2016. The figure below shows the payment progression from FY 2012 to FY 2016.



- **Decrease % of Core Measures Performance (move away from Process Measurement)**
- **Sustained focus on Patient Satisfaction (25-30%)**
- **Increase % of Outcome Measures**
- **Addition/increase % of Efficiency Measure**

Highlights from our CPIC Report

Publically Reported Metrics

Hospital Acquired Conditions (HACs)	Units	FY 2014	Trend	FY 2013
CAUTI	% rate	0.1	⇔	0.06
VTE	% rate	0.6	↗	0.37
Sepsis	% rate	1.7	↗	1.03
Respiratory Failure	% rate	1.9	⇔	1.92
C-Diff	% rate	0.3	↘	0.62
Mortality Index		**FY 2014**	**Trend**	**FY 2013**
Overall	(O/E)	0.9	↘	0.93
Sepsis	(O/E)	1.0	⇔	1.01
Pneumonia	(O/E)	0.7	↘	0.78

HACs

We measure HACs using UHC billing data. VTE and Sepsis are the most notable increases this year.

Mortality Index

Hospitals are judged by

Those that actually die

Observed Mortality
Expected Mortality

Those that were expected to die based on our documented severity of illness

We continue to struggle with Sepsis Mortality! Our initial investigations suggest that the issues are 1) Patients made comfort care without all documented comorbidities, 2) Coders are resistant to code sepsis when not in d/c summary.

Operational Service Metrics

Metric	Units	FY 2014	Trend	FY 2013
Inpatient Volume	Discharges	**5,540**	↗	4,687
LOS Index	O/E	**1.06**	↗	1.01
ICU Cases	%	**17.65**	⇔	17.56
Mean ICU Utilization	Days/pt	**5.12**	⇔	5.67
Medicare Case Mix Index		**1.64**	⇔	1.62
Non-Medicare Case Mix Index		**1.42**	⇔	1.38
Direct Cost per Case (observed)	$/patient	**15,610**	↗	14,611
Direct Cost Index	O/E	**1.8**	⇔	1.62

This year has seen less impressive improvements than in FY 13…

- Volume Increase by 18.2%
- LOS increase by 4.95%, preliminary analysis suggests interplay with DBN efforts
- Increase in Direct Cost per Case

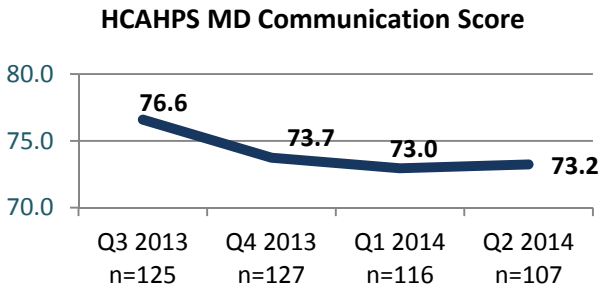
Readmission Rates

Metric	Units	FY 2014	Trend	FY 2013
DHM All Cause Readmissions	% rate	**15.5**	⇔	15.7
DHM All Cause Readmissions >65	% rate	**14.6**	⇔	14.2
Sepsis	% rate	**17.2**	↗	15.32
Pneumonia	% rate	**10.8**	↘	18.02
Pneumonia>65	% rate	**11.9**	↘	16.33
Kidney and UTI	% rate	**16.3**	⇔	15.69
COPD	% rate	**22.1**	⇔	23.81

- All Cause readmission rates have stayed largely stable over the last three years
- We've been working on partnerships with PCPs & Post-Acute Providers to improve care coordination
- We are analyzing opportunities to improve care from the post-discharge phone call program

Highlights from our CPIC Report

Patient Experience



Performance decreased in the last two quarters. HCAHPS remains a high-priority for our division, and we plan to revamp our coaching and data feedback efforts this year to improve our percentile rank in FY15.

Education/Messaging	Increased education and simplified goals for housestaff (PQJ, Moffitt Made Easy, New Faculty and Fellows training, DHM patient experience wiki resource page); Coordinating efforts across VA and SFGH
Data Audit and Feedback	HCAHPS data shared regularly with faculty and housestaff at monthly conferences and via email; planning to increase individual/team data feedback efforts in FY15
Systems Change Initiatives	Take a Seat, Patient Passport, Rounding Revamp, FaceCards
Culture Change	HCAHPS Division Incentive Metric, Attending Modeling

Infection Surveillance

Metric	Units	FY 2014	Trend	FY 2013
Sepsis Full Bundle Compliance	% compliance	**83**	⇔	84.5
Hand Hygiene Compliance for Parnassus (MD)	% compliance	**93.1**	⇔	95

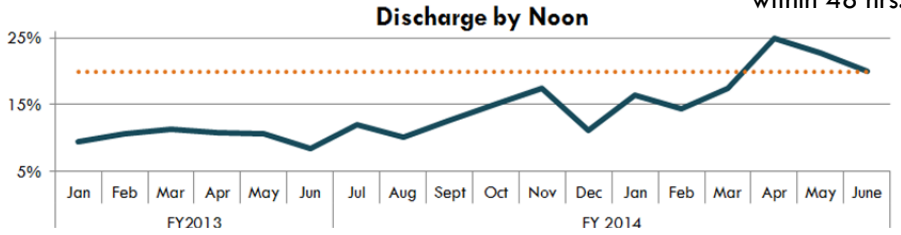
We are still doing well on our Sepsis Bundle Compliance and Handy Hygiene!

Transitions in Care

Metric	Units	FY 2014	Trend	FY 2013
AVS quality: DC diagnosis, Patient instructions & follow up appts	% compliance	**82.5**	↗	40
Resident DC summary within 48 hours	% compliance	**94**	⇔	93
Attending DC Summary within 48 hours	% compliance	**73**	↘	84

This year has seen impressive improvements in Care Transition metrics.

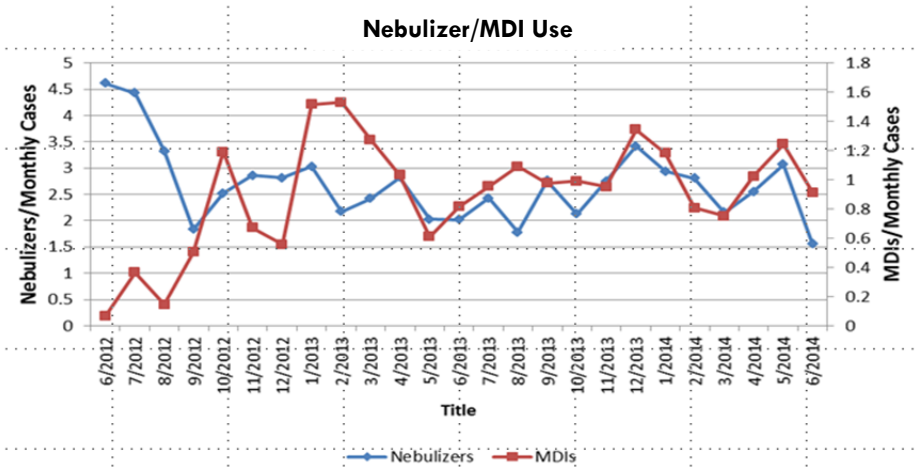
- We achieved our Division Incentive Discharge by Noon metric and maintained our compliance with PCP follow-up appointment within 14 days metrics.
- We still have some work to do to improve Attending DC summaries within 48 hrs.



Highlights from our CPIC Report

Operations and High-Value Care

Metric	Units	FY 2014	Trend	FY 2013
ED Throughput: Average Decision to Order times	minutes	**126**	↔	125
Use of Nebulizer Therapies / case	Nebs per case	**2.5**	↘	2.7
Transfusions for Hgb ≤8.0	% compliance	**12.1%**	↘	30%
% of patients on tele until discharge	% compliance	**35.7%**	↘	44%



M&M/Case Review

Metric	FY 2014	Trend	FY 2013
SCHMRC with rating ≥3	24/243	↔	21
Communication Errors	12/34	↔	16
Medication Errors	10/34	↔	5
Transfer/Flow/Triage Errors	4/34	↔	8
Diagnostic Errors / Risks/ Assessment	16/34	↔	18
Sepsis	0/34	↔	8
Code Blue	1/34	↔	12
Cases brought to full case review	57/78	↔	57
Housestaff & Faculty M&Ms	12/78	↔	12

We partner with SCHRMC and Code Blue committee to get timely referral of cases. We review all Code Blue cases and SCHMRC cases scored ≥3 for potential quality triggers and refer cases with concerning findings for formal review

There were no Medicine RCAs for this reporting period.

Notable Cases:
1. Code Blue Miscommunication: Patient with evolving code status who was not yet DNR/DNI. Team de-escalating therapy, nurse believed the patient was DNR/DNI did not call a code for several minutes when patient was found unresponsive.

2. Paracentesis Complications: We reviewed two cases of poor outcomes (shock & hemorrage after paracentesis). Both patients were deteriorating prior to the procedure, however both were performed with clear informed consent after extensive discussion of risks vs. benefits with patient and team.

Division Incentive Metric Performance

Decrease number of total phlebotomy draws by from 2.05 to 1.9 sticks (7.3%) per hospitalized patient per day							3 of 12 months					
FY2014 Baseline	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
2.05	1.98	2.11	1.87	1.98	2.09	2.03	1.96	2.02	1.97	1.91		

Decrease total telemetry hours / DHM discharges from 35 hours to 30 hours (15%)							6 of 12 months					
FY2014 Baseline	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
35 hrs	33.9	30.5	29.2	24.2	27.7	39.8	**24**	32.5	**28.8**	32.1		

Achieve HCAHPS Communication with Doctors Top Box score above 80%							6 of 12 months					
FY2014 Baseline	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
74.6%	67.4	79.3	75.4	68	86	77.1	72.5	**82.1**				

Achieve 20% of hospital medicine discharges by noon							6 of 12 months					
FY2014 Baseline	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
15.7%	15.9	14.0	16.9	24.3	20.3	18.5	14.8	**20.2**	**20.7**	14.2	16.4	

Improve 14-day UCSF PCP follow-up appointments scheduled, with appointments scheduled by 5 days after discharge, to 80%							3 of 12 months					
FY2014 Baseline	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
68%	72.2	72.0	68.5	72.3	78.1	66.9	64.1	75.5	**80.5**			