


HRET
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

**QUALITY is from Mars,
COST is from Venus.**

Anne Arundel Health System
March 16, 2009

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TRANSFORMING HEALTH CARE THROUGH RESEARCH AND EDUCATION





**Top Ten
Healthcare Transformers**

**“10 things, when put together
reliably and consistently, will
significantly alter the way
healthcare is delivered and
financed.”**

HRET

10. Implementing the “Basics”

- Reduce surgical site infection
 - Timely use of antibiotics (82%)
- Improve care for patients with congestive heart failure
 - ACE Inhibitors or ARBs used (84%)
 - Discharge instructions (66%)
 - Smoking cessation counseling (86%)
- Implement rapid response teams (17% survival rate for cardiac arrest)
 - Assess; Stabilize; Communication; Educate
- Prevent pressure ulcers (7% prevalence)
 - Conduct risk assessments
 - Inspection; pressure minimization
- Prevent central line-associated bloodstream infections (18% attributable mortality; \$25,000 cost)
- Open access scheduling (10% to 50% not accommodated)
 - Match supply and demand



10. Implementing the “Basics”

How to Implement a Rapid Response Team

- Engage senior leadership support.
- Team composition (Multiple Models: ICU RN and Respiratory Therapist (RT); ICU RN, RT, Intensivist, Resident; ICU RN, RT, Intensivist or Hospitalist; RN, House Supervisor, RT)
- Establish criteria for calling the Rapid Response Team (e.g., acute changes, staff, family activation).
- Establish a simple process for calling the Rapid Response Team. (e.g., beeper, overhead page, companion phone)
- Provide education and training.
- Use standardized tools (e.g., SBAR).
- Establish feedback mechanisms.
- Determine the best structure for the Rapid Response Team.
- Measure effectiveness.



10. Implementing the “Basics”

Large Potential Gains from the “Basics”

“If we **DO** what we **KNOW**, the potential to improve health is more than finding cures for diabetes, heart disease or cancer in the next twenty years.”

-Ken Kizer, MD

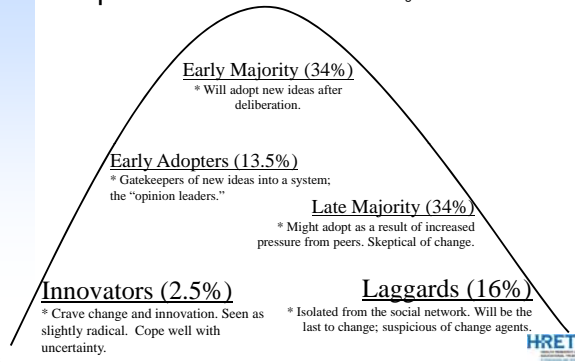


10. Implementing the "Basics"

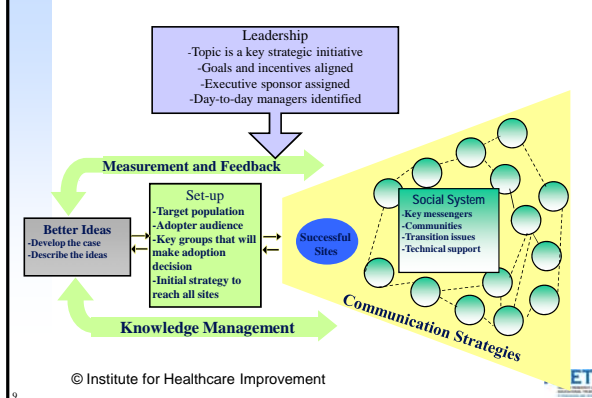


9. Spread

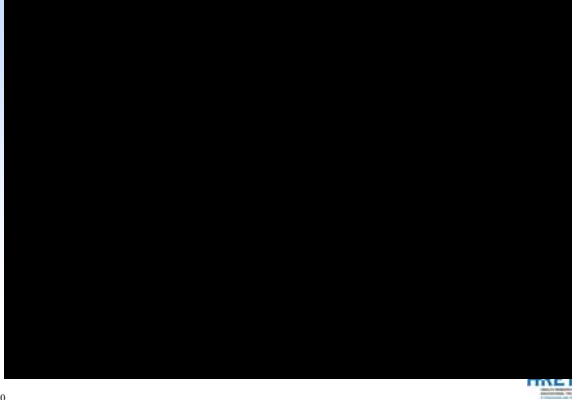
Adoption of Innovation – E. Rogers



A Framework for Spread



Learn How to Learn



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8. Focus on the Patient

- Involve patients/families in improvement teams
- Share patient stories with leadership and governance
- Patients/families on advisory councils
- Patients/families part of leadership walkarounds
- Patients/families part of daily rounds
- 24/7 open hours for patients/families
- Full and easy access to health records
- Educational materials appropriate for population
- Translation services offered

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Questions are the Answer

Patient Involvement Campaign by AHRQ and the AD Council

- A Web site that features a "Question Builder" for patients to enhance their medical appointments
- The message: Get More Involved With Your Health Care



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7. Coordination of Care

- Between settings (hospital and nursing home)
- Between services (x-ray and specialist)
- Between people (shift to shift or within the doctor's office)

Opportunities:

- Electronic Health Records
- Integrated, accountable systems
- Community level systems

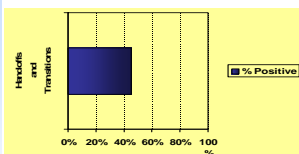


7. Coordination of Care



7. Coordination of Care

AHRQ Hospital Survey on Patient Safety Culture



n=600 hospitals,
>100,000 respondents

- Things fall between the cracks when transferring patients from one unit to another
- Important patient care information is often lost during shift changes
- Problems often occur in the exchange of information across hospital units
- Shift changes are problematic for patients in this hospital

<http://www.ahrq.gov/qual/hospsurveydb/>



6. Payment Redesign

Pay for performance (healthcare)

From Wikipedia, the free encyclopedia

Pay for performance is an emerging movement in **health insurance** (initially in Britain and United States). Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This is a fundamental change from fee for service payment.

Also known as "P4P" or "value-based purchasing," this payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency. Disincentives, such as eliminating payments for negative consequences of care (medical errors) or increased costs, have also been proposed. In the developed nations, the rapidly aging population and rising health care costs have recently brought P4P to the forefront of health policy discussions. Pilot studies underway in several large healthcare systems have shown modest improvements in specific outcomes and increased efficiency, but no cost savings due to added administrative requirements. Statements by professional medical societies generally support incentive programs to increase the quality of health care, but express concern with the validity of quality indicators, patient and physician autonomy and privacy, and increased administrative burdens.

6. Payment Redesign

- Quality Bonuses
- Compensation at Risk
- Variable Cost Sharing for Patients
- Tiered Networks
- Reduce administrative/other requirements
- Bundled Payments
- Payment Guarantees
- Not paying for never events
- *Pay for Meeting Targets*
- *Pay for Demonstrating Improvement*

Why it matters: Higher quality yields lower cost

PREMIER

Total Cost by Composite Process Score
Pneumonia

Composite Process Score	Total Cost
CPS 0 to 25%	\$11,400
CPS 26 to 50%	\$9,600
CPS 51 to 75%	\$8,800
CPS 76 to 90%	\$8,200
CPS 91 to 100%	\$7,800

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5. Organizational Quality Improvement Capability

- Quality improvement as a requisite leadership skill
- Rigor and discipline for organizational performance tracking
- Quality improvement training in professional education
- Quality improvement taught as a science discipline



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4. Transparency

Schneider and Epstein

JAMA 1998;279:1630-1642.

Context.— Publicly released performance reports ("report cards") are expected to foster competition on the basis of quality. Proponents frequently cite the need to inform patient choice of physicians and hospitals as a central element of this strategy.

Objective.— To examine the awareness and use of a statewide consumer guide that provides risk-adjusted, in-hospital mortality ratings of hospitals that provide cardiac surgery.

Design.— Telephone survey conducted in 1996.

Setting.— Pennsylvania, where since 1992, the Pennsylvania Consumer Guide to Coronary Artery Bypass Graft (CABG) Surgery has provided risk-adjusted mortality ratings of all cardiac surgeons and hospitals in the state.

Participants.— A total of 474 (70%) of 673 eligible patients who had undergone CABG surgery during the previous year at 1 of 4 hospitals listed in the Consumer Guide as having average mortality rates between 1% and 5% were successfully contacted.

Main Outcome Measures.— Patients' awareness of the Consumer Guide, their knowledge of its ratings, their degree of interest in the report, and barriers to its use.

Results.— Ninety-three patients (20%) were aware of the Consumer Guide, but only 56 (12%) knew about it before surgery. Among these 56 patients, 18 reported knowing the hospital rating and 7 reported knowing the surgeon rating. 11 said hospital and/or surgeon ratings had a moderate or major impact on their decision making, but only 4 were able to specify either or both correctly, when the Consumer Guide was described to all patients, 264 (56%) were "very" or "somewhat" interested in seeing a copy, and 273 (58%) reported that they probably or definitely would change surgeons if they learned that their surgeon had a higher than expected mortality rate in the previous year. A short time window for decision making and a limited awareness of alternative hospitals within a reasonable distance of home were identified as important barriers to use.

Conclusions.— Only 12% of patients surveyed reported awareness of a prominent report on cardiac surgery mortality before undergoing cardiac surgery. Fewer than 10% knew the correct rating of their surgeon or hospital and reported that it had a moderate or major impact on their selection of provider. Efforts to aid patient decision making with performance reports are unlikely to succeed without a tailored and intensive program for dissemination and patient education.

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Maryland Board of Physicians Practitioner Profile System

This data was extracted on 02/13/2009

License and Education	Meisenberg, Barry R Primary Practice Setting	Public Address
License No.: D51260		Arno Arundel Medical Center
Accepts Medicaid: Yes		2001 Medical Parkway
Graduated: 1982		Annapolis
License Status: Active		MD 21401
Date License Issued: 10/02/1998		
License Expiration: 09/30/2009		
Graduated from: ALBANY MED COLL		
Postgraduate Training Program	Concentration	
• Naval Hospital, San Diego, CA	Medicine, Internal [General]	
• US Naval Hospital, San Diego, CA	Hematology (Internal Medicine)	
Specialty Board Certification by ABMS/ACC - as reported by licensee		
• Oncology, Medical [General]		
• Hematology (Internal Medicine)		
Self-Designated Practice Area		
• Hematology (Internal Medicine)		
• Oncology, Medical [General]		

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National Rankings for Hospitals Per State¹
MARYLAND
 Copyright © HealthGrade 2008

Hospital	City	National Ranking (percentile)	AMI - Performance Rate (percent)	Heart Failure - Performance Rate (percent)	Pneumonia - Performance Rate (percent)	SCIP - Performance Rate (percent)
SANT MARY'S HOSPITAL	LEONARDTOWN	34th	100%	94%	97%	97%
UNION MEMORIAL HOSPITAL	BALTIMORE	32nd	97%	95%	91%	96%
UPPER MERIDIAN MEDICAL CENTER	BEL AIR	33rd	96%	94%	94%	95%
GREATER BALTIMORE MEDICAL CENTER	BALTIMORE	33rd	99%	97%	93%	94%
MERCY MEDICAL CENTER INC	BALTIMORE	31st	96%	96%	92%	94%
HARFORD MEMORIAL HOSPITAL	HARVEE DE GRACE	79th	92%	96%	92%	94%
UNIVERSITY OF MARYLAND MEDICAL CENTER	BALTIMORE	79th	98%	95%	87%	94%
SANT JOSEPH MEDICAL CENTER	TOWSON	78th	97%	96%	92%	91%
FRANKLIN SQUARE HOSPITAL CENTER	BALTIMORE	77th	94%	88%	93%	95%
ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	75th	98%	97%	86%	94%

1. For all hospitals reporting during 2nd quarter 2007 through 1st quarter 2008 (4/1/07 to 3/31/08).

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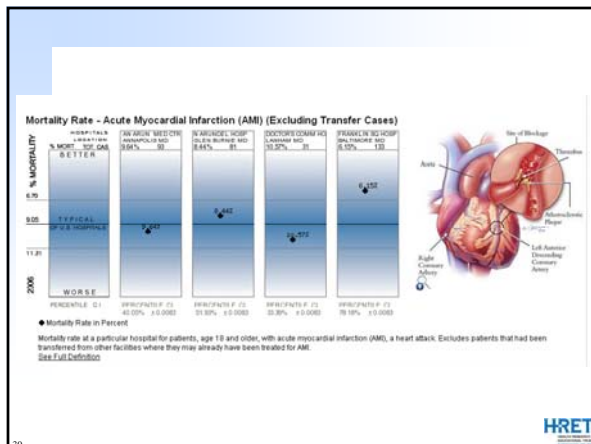
2008/2009 Hospital Quality Ratings: Maternity Care

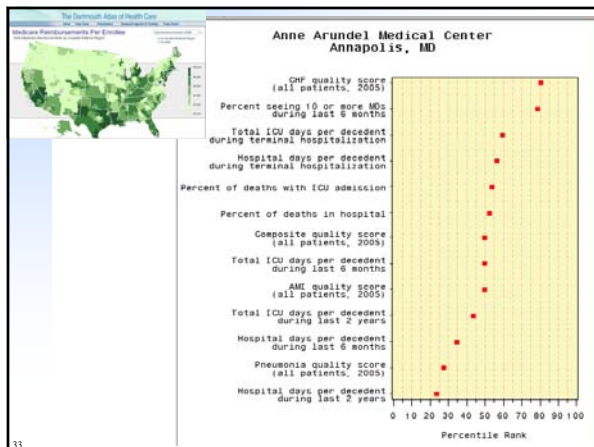
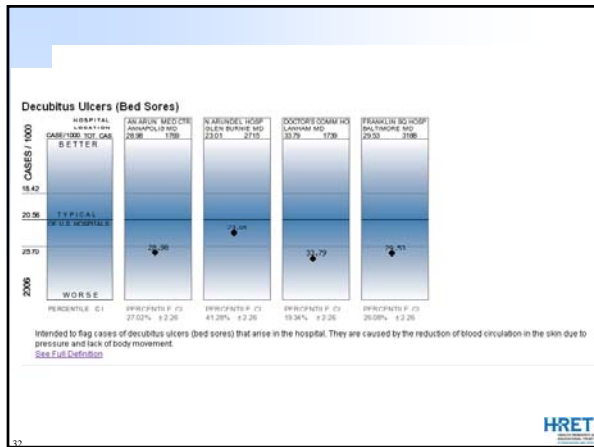
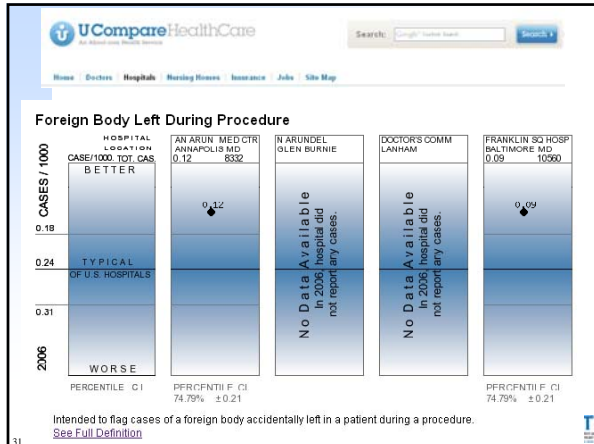
Hospital's Name	Location	Rating
St. Mary's Hospital	Silver Spring, MD	★★★★★ Best
Washington Adventist Hospital	Takoma Park, MD	★★★★ As Expected
Prince Georges Hospital Center	Chesley, MD	★★★★ As Expected
Shady Grove Adventist Hospital	Federalsville, MD	★★★★ As Expected
Anne Arundel Medical Center	Annapolis, MD	★★★★ As Expected
Leesville Regional Hospital	Leesville, MD	★★★ As Expected
Montgomery General Hospital Inc	Olney, MD	★★★ As Expected

Cases: 1400
 Readmission: 9.2%
 Length of Stay: 4.2 days

Complications: 9.7%
 Complications: Patient Choice C Section: 1.8%

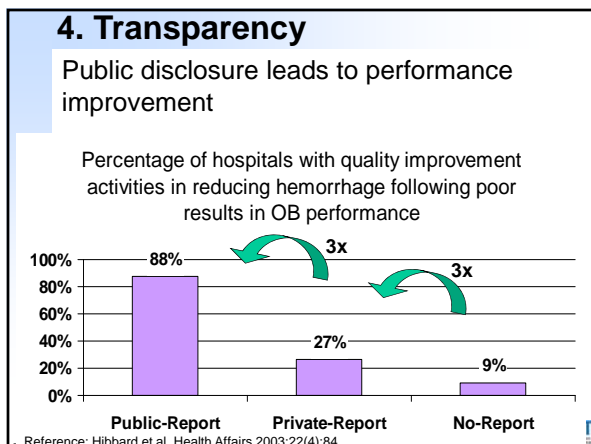
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Total ICU days per decedent during the last two years of life					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	5.21	-	-
*State Average	Pennsylvania	245,147	6.81	0.77	-5,223
*State Average	Massachusetts	101,124	5.35	0.98	-436
*State Average	Minnesota	65,135	4.49	1.16	2,342
Total ICU days per decedent during the hospitalization in which death occurred					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	1.38	-	-
*State Average	Massachusetts	101,124	1.38	1	-4
*State Average	Pennsylvania	245,147	1.36	1.01	67
*State Average	Minnesota	65,135	1.06	1.31	1,055
Deaths by location percent of deaths associated with icu admission					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	19.61	-	-
*State Average	Pennsylvania	245,147	20.33	0.96	-24
*State Average	Massachusetts	101,124	18.22	1.08	45
*State Average	Minnesota	65,135	15.57	1.26	132

Deaths by location percent of deaths occurring in hospital					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	35.32	-	-
*State Average	Massachusetts	101,232	36.88	0.96	-51
*State Average	Pennsylvania	246,081	34.33	1.03	33
*State Average	Minnesota	68,388	30.72	1.15	150
Total ICU days per decedent during the last six months of life					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	2.95	-	-
*State Average	Pennsylvania	245,147	4.19	0.7	-4,033
*State Average	Massachusetts	101,124	2.62	1.13	1,093
*State Average	Minnesota	65,135	2.21	1.34	2,421
Percent of decedents seeing 10 or more different physicians during the last six months of life					
Hospital Level Rates (2001-2005)					
Hospital	Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Anne Arundel Medical Center	Annapolis , MD	3,265	45.31	-	-
*State Average	Pennsylvania	246,081	45.65	0.99	-11
*State Average	Massachusetts	101,232	45.41	1	-3
*State Average	Minnesota	68,388	31.36	1.44	455



MN Community Measurement News



3. Governance

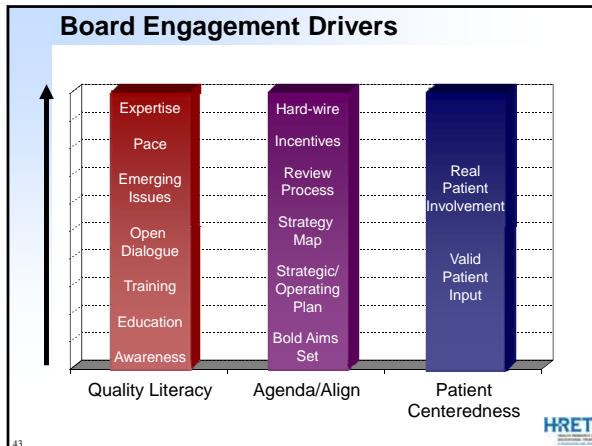
What does the "evidence" tell us about what Boards can do to accelerate improvement?

From Emerging Research and Case Studies of High Performing Organizations

- Alexander JA, Lee SD. Does governance matter? Board configuration and performance in not-for-profit hospitals. *The Milbank Quarterly*. 2006;84(4):733.
- Bisognano M, McCannon J, Botwinick L. A campaign for 100,000 lives: The time is now for boards to lead quality and safety efforts. *Trustee*. 2005;58(8):12-14,19,1.
- *Hospital Governing Boards and Quality of Care. A Call to Responsibility*. National Quality Forum; 2004.
- Joshi MS, Hines SC. Getting the board on board: Engaging hospital boards in quality and patient safety. *Joint Commission Journal on Quality and Patient Safety*. 2006;32(4):179-187.
- Kroch E, Vaughn T, Koepke M, Roman S, Foster D, Sinha S, Levey S. Hospital boards and quality dashboards. *Journal of Patient Safety*. 2006;2(1):10-19.
- Locke C, Kroom K, Zablocki E, Bader B. *Quality: The Governance Institute*. 2006.

Data from a Health System Board

Survey Question	% "Sometimes" or "No"
The Board holds crucial conversations about system failures that resulted in patient harm.	60%
The Board invests time at Board meetings to understand the gap between current performance and the best in class.	67%
The Board takes ownership of quality problems and makes quality an agenda item at every Board meeting.	73%
The Board's knowledge of quality and safety issues is comparable to its knowledge of the institution's financial health.	73%



2. Culture

- Shared beliefs, perceptions, expectations of individuals in organizations
- “Culture eats strategy for lunch everyday”
- Strong link between culture and results – financial, innovation, safety, satisfaction
- Many dimensions –
 - Team work is one critical component

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Culture Change - Team

- “Can Health Care Teams Improve Primary Care Practice?” Grumbach K., Bodenheimer T. *JAMA*, March 10, 2004, Vol 291, No. 10.
- Who is on the team and **How do they work together?**
- 5 Key Characteristics of cohesive teams:
 - Clear goals with measurable outcomes
 - Clinical and administrative systems
 - Division of labor
 - Training of all team members
 - Effective Communication

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Team Dynamics

- *Vision* – A shared mental model of values and intentions supported by measures
- *Leadership* – Role of “culture makers”, alignment across units
- *Hierarchy* – Control and information flow
- *Mindfulness* – Openness, accurate perception and awareness of bias
- *Teamwork* – Interpersonal communication, conflict management



Team Dynamics

- *Cross Unit Handoffs* – Unit to unit
- *Learning* – Changes based on experience
- *Openness* – Freedom to speak out
- *Safety Info* – Opportunity
- *Management support* – Focus on safety
- *Information Exchange* – Shift to shift

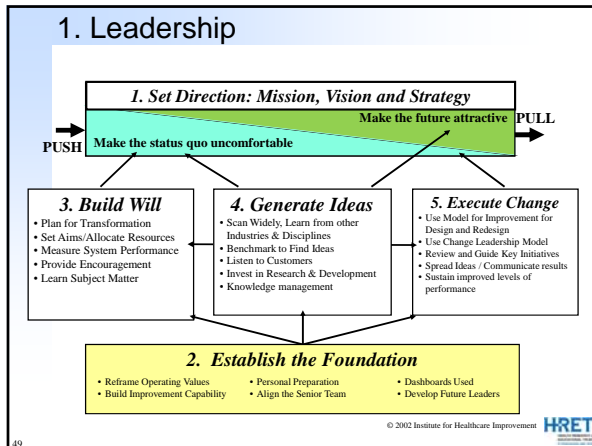


AHRQ Hospital Survey on Patient Safety Culture

- “Administration/Management” had the highest percent positive on 11 of the 12 composites
- Physicians tend to be more positive
 - “Staff feel free to question the decisions or actions of those with more authority.” (Physicians=57% positive; Nurses=45%; Patient Care Assistants=39%)
- “When a mistake is made, but caught and corrected before affecting the patient, how often is this reported?” (50% positive)
- “Staff worry that mistakes they make are kept in their personnel file.” (35% positive, lowest score of all the items)

<http://www.ahrq.gov/qual/hospsurveydb/>





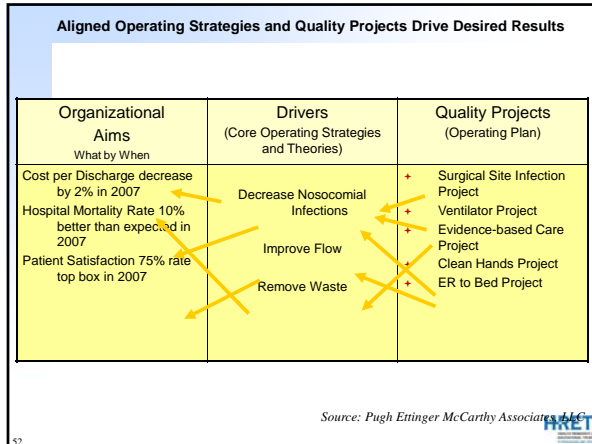
- ### Examples of Big Dots/Outcomes
- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Mortality ▪ Readmission Rates ▪ Patient Experience ▪ % of Patients Receiving Care According to the Evidence (All or none) ▪ Harm rate ▪ Functional outcomes | <ul style="list-style-type: none"> ▪ Employee Satisfaction, Loyalty or Engagement ▪ Cost per Discharge ▪ Cost per episode ▪ Days Cash on Hand ▪ Patient Safety ▪ Access |
|--|---|
- 50

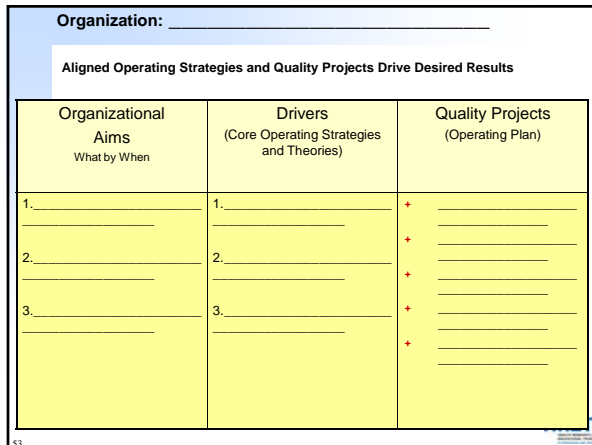
Creating Alignment Between Desired Results and Quality Projects

Organizational Performance Measures	Drivers (Core Strategies and Theories)	Quality Projects (Operating Plan)
<ol style="list-style-type: none"> 1. What are your system level aims and aspirations? 2. What are the system-level measures of those aims? (Big Dots) 3. How good must you be, and by when? 	<ol style="list-style-type: none"> 1. What are your key organizational strategies for moving your dots? 2. What really has to be changed, or put in place, in order to achieve each of these goals? 	<ol style="list-style-type: none"> 1. What set of projects will move the Drivers far enough, fast enough, to achieve your aims?

Source: Pugh Ettinger McCarthy Associates, LLC

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- Execute Change**
- Leaders need to build accountability
 - Support through resources
 - Participate on project teams
 - Think System Changes
 - **Culture is the key**

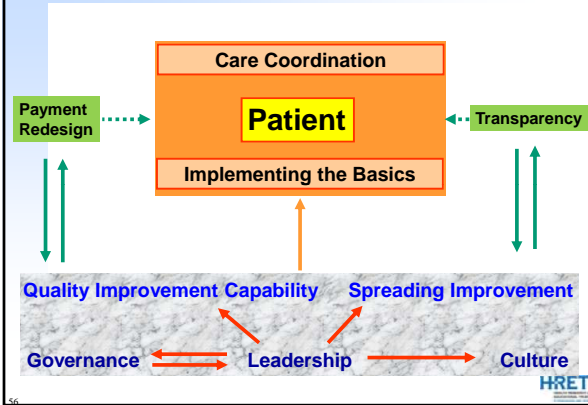
Top Ten Transformers

1. Leadership
2. Culture
3. Governance
4. Transparency
5. Building Organizational Quality Improvement Capability
6. Continued Experimentation with Payment Redesign
7. Emphasis on Coordination of Care
8. Focus on the Patient
9. Developing Translational Learning/Spreading Improvement
10. Implementing the Basics: Open Access; Infection Prevention; Rapid Response Teams; etc.

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Top Ten Transformers

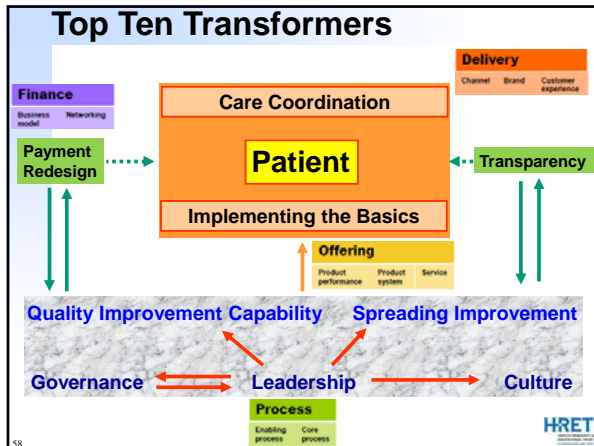


Quality AND Cost

- Bundle payments
 - Hospital and post acute
 - Hospital and physician
- Reduce payment for high readmissions
- Expand Hospital Quality Incentive Program
- Reduce variation by reducing payments in high spending areas

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The book cover for **Healthcare Transformation: A Guide for the Hospital Board Member** features a 3D bar chart with four bars in yellow, green, blue, and red. The authors are Maulik S. Joshi, MD and Bernard J. Borak, MD. The book is foreworded by John R. Gaudes, MD. The HRET logo is located in the bottom right corner of the slide.
