

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

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HEALTH RESEARCH & EDUCATIONAL TRUST



**Top Ten
Healthcare Transformers**

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

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HEALTH RESEARCH & EDUCATIONAL TRUST

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”

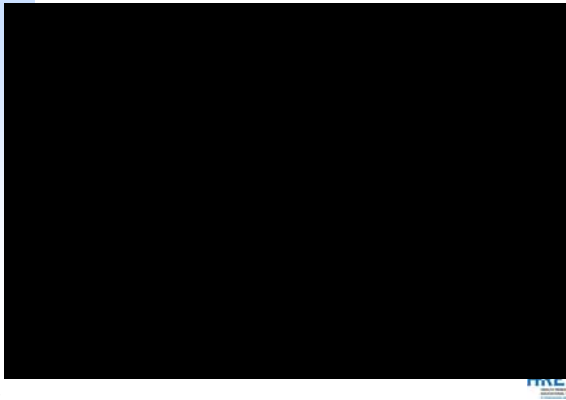
Large Potential Gains from the “Basics”

“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

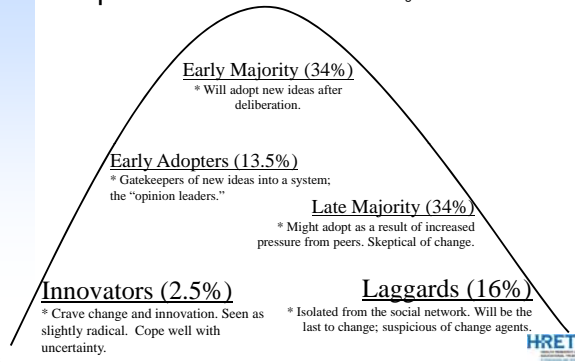


10. Implementing the "Basics"

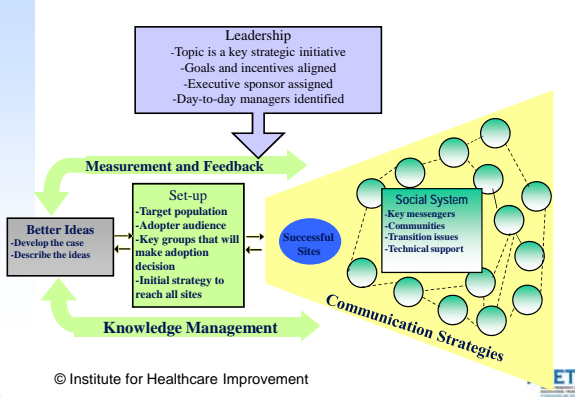


9. Spread

Adoption of Innovation – E. Rogers



A Framework for Spread



Learn How to Learn



10



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



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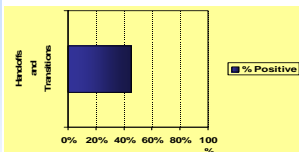
7. Coordination of Care



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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/>



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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;279:1638-1642.

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 1% 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

Meisenberg, Barry R

License and Education	Primary Practice Setting	Public Address
License No: DS1260		Arise Arunde 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 ABIMSS (C.C.) - as reported by licensee
• Oncology, Medical [General]
• Hematology (Internal Medicine)

Self-Designated Practice Area
• Hematology (Internal Medicine)
• Oncology, Medical [General]

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Maryland Hospital Privilege Information

Anne Arundel Medical Center

Known Disciplinary Actions by any state medical board (within the past 10 years)
Summary: No actions reported during the last ten year period.

Download all Maryland Disciplinary Actions
None

Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)
Malpractice Judgments and Arbitration Awards (within the past 10 years)
None Reported

Malpractice Settlements
(If there are 3 or more settlements of \$150,000 or greater within the past 5 years)
None Reported

Convictions for any crime involving moral turpitude
None reported by the courts

[Glossary of Terms](#)

[Notice to Credential Verification Professionals](#)

[Return to Practitioners Profile Search](#)




UCompareHealthCare
THE HOSPITALITY GROUP

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Doctor QuickCheck Report™
 Based on the criteria you used and the doctors you selected, here is your UCompareHealthCare report.

Practice Locations | Public Action | Specialty & Hospital Affiliations | Education | Things to Consider | Questions | Definitions

NAME	GENDER	ADDRESS	ADDRESS
Dr. Stephen Edward Faust	Male	Orthopaedic & Sports Medicine Center 118 Forbes St Annapolis, MD 21401 Practice: (410) 268-6862	Orthopaedic & Sports Medicine Center 4175 N Hanson Ct Suite 201 Bowie, MD 20716 Practice: (410) 268-6862
Dr. Paul J King	Male	Anne Arundel Orthopaedic Surgeons 2003 Medical Pkwy Suite 400 Annapolis, MD 21401 Practice: (410) 673-2530	Anne Arundel Orthopaedic Surgeons 4175 N Hanson Ct Suite 104 Bowie, MD 20716 Practice: (800) 331-2486



Practice Locations | **Public Action** | Specialty & Hospital Affiliations | Education | Things to Consider | Questions | Definitions

NAME	STATE	FEDERAL
Dr. Stephen Edward Faust	None Found	None Found
Dr. Paul J King	None Found	None Found


Public Action
 *UCompareHealthCare (UHC) found no Federal or State public actions the report states "None Found."

Feder of Exclusions
 UCompareHealthCare obtains data from the Office of Inspector General (OIG) which lists individuals who have been barred from participating in federally funded healthcare programs. This is known as exclusion. There are several reasons for exclusion, including:

- i. conviction relating to fraud
- ii. misdemeanor conviction relating to controlled substances
- iii. license revocation by the State Medical Board
- iv. surrender of a medical license while formal disciplinary actions are proceeding
- v. any exclusion from any federal or state health programs
- vi. claims for excessive charges, fraud, or kickbacks
- vii. failure to report required information to various state and/or government agencies
- viii. failure to grant immediate access for various inspections
- ix. failure to take corrective action on issues found during inspections
- x. default of health education loans or scholarship obligations

State Medical Board Public Action Data
 State Medical Board public action data is provided, if it is available, for the state in which the physician practices. UCompareHealthCare makes every effort to ensure that this data is up-to-date in accordance with what is reported by the state medical board. The scope of this data varies by state, but generally covers public actions inclusive of:

- i. Actions taken by the State Medical Board
- ii. Actions taken by Hospitals
- iii. Criminal convictions
- iv. Administrative actions



Dr. Paul King - Annapolis, MD Doctor Ratings

YOUR DOCTOR

Dr. Paul King

1 Rating: 5
Average Helpfulness: 0.0
Average Knowledge: 5.0
Overall Quality: 5.0
Range: 1-5 (5 is best)

The following ratings and comments have not been substantiated by RateMDs.com.

Date **Comments**

7/26/08 5 5 5
The doctor is fantastic; however, his staff is absolutely the worst. I love Dr. King and wish I wasn't moving away. He is pleasant to talk to, takes the time to answer questions, and is conservative in his approach to medicine. He definitely knows his stuff and has been instrumental in advancing the state of practice in knee replacement surgery. But he needs to fire his entire staff and get people working for him that CARE for the patient. They are rude, don't relay complete messages, and do nothing to help connect you with the doctor.
Insurance: Blue Cross / Blue Shield

Dr. Thomas B. Ducker

Annapolis, MD

Gender: M
Specialty: Neurosurgery

Webpage:
Hospital:
Answers Email:
Online Appt. Scheduling:
Accepting New Patients:
Phone Number: 410-224-0545

1 Rating: 5
Average Helpfulness: 0.0
Average Knowledge: 5.0
Overall Quality: 5.0
Range: 1-5 (5 is best)

"I Cured My Wrinkles!"
Learn How a Mom Combined 2 Products to Get Rid of Her Wrinkles Forever...

Date **Comments**

5/22/07 5 5 5
I found Dr. Ducker to be very upfront about things and he is a very concerned Dr. - about your condition but he will not tell you what he thinks you need to hear - he will tell you the truth.

Dr. Douglas Mitchell, MD

Hospital Affiliations

5 Star Rating (5 is Best)

Nearby Area Hospitals

Clinical Service Area	Anne Arundel Medical Center, Annapolis, MD	Ballmore Washington Medical Center, Glen Burnie, MD	Doctor's Community Hospital, Lushton, MD
Bariatric Surgery	●	●	●
Cardiac	●●●●●	●●●●●	●●●●●
Critical Care	●●●●●	●●●●●	●●●●●
Gastrointestinal	●●●●●	●●●●●	●●●●●
General Surgery	●●●●●	●●●●●	●●●●●
Orthopedic	●	●●●●●	●●●●●
Pulmonary	●●●●●	●●●●●	●●●●●
Stroke	●●●●●	●●●●●	●●●●●
Vascular	●●●●●	●●●●●	●●●●●
Women's Health	●●●●●	●	●

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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HEALTHGRADES
 RAISING STANDARDS TO BETTER HEALTHCARE

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Current Ratings | Previous Ratings | America's 50 Best Hospitals | Clinical Excellence Data | Patient Safety Data | Specialty Excellence | Outstanding Patient Experience

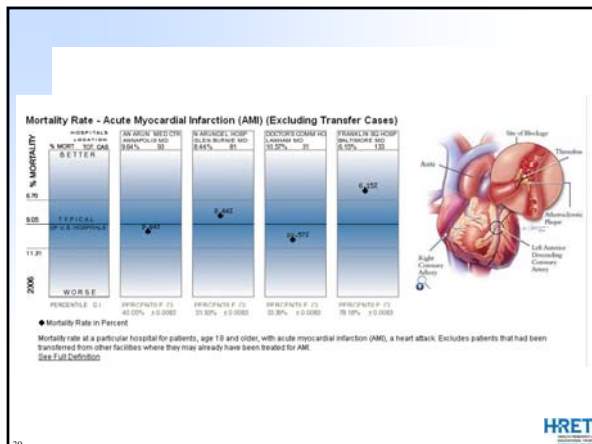
2008/2009 Hospital Quality Ratings: Maternity Care

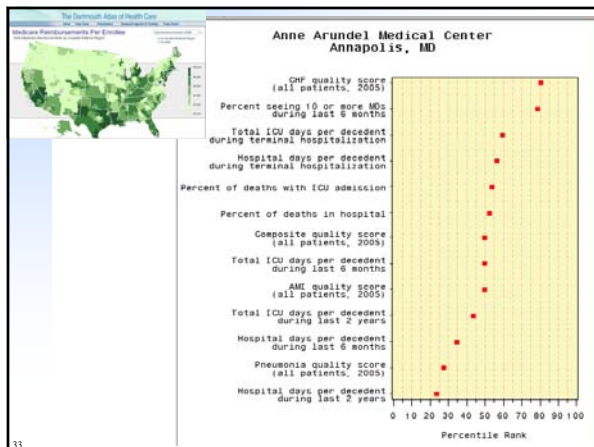
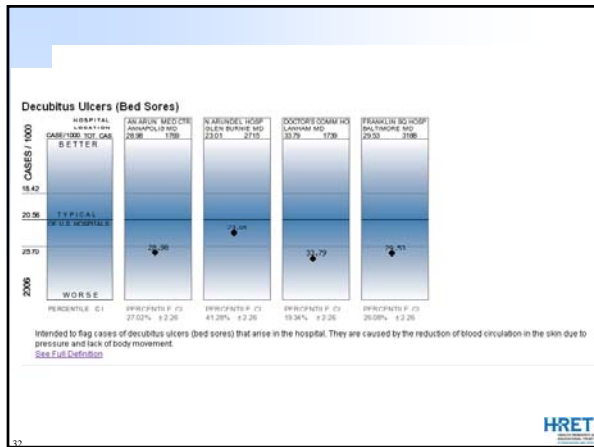
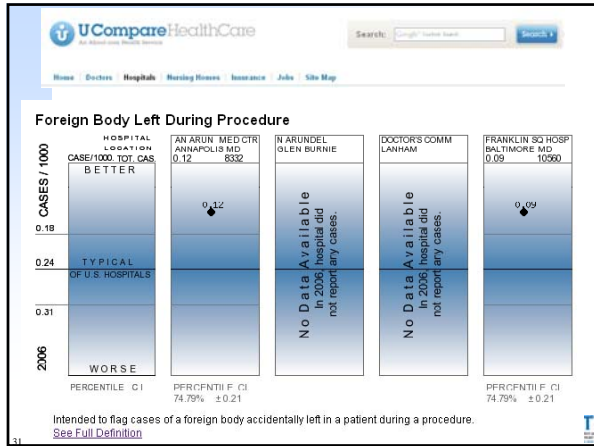
Hospital's Name	Location	Rating
St. Mary's Hospital	Silver Spring, MD	★★★★★
Washington Adventist Hospital	Takoma Park, MD	★★★★
Prince Georges Hospital Center	Chesley, MD	★★★
Shady Grove Adventist Hospital	Federalsville, MD	★★★
Anne Arundel Medical Center	Annapolis, MD	★★★
Leidos Regional Hospital	Lanham,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

Cases: 1400
 Readmission: 9.8%
 Length of Stay: 4.2 days

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

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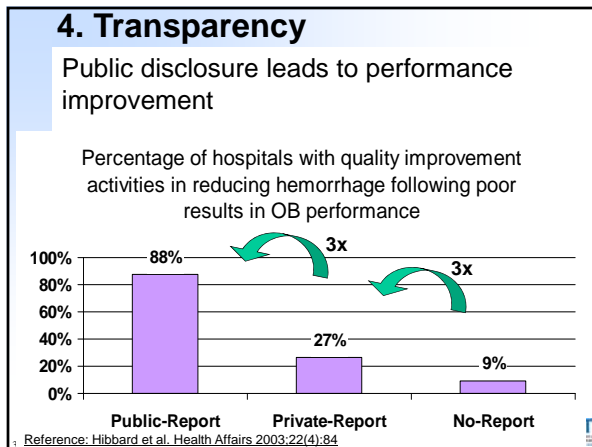
Anne Arundel Medical Center (2001-2005)			
Variable	Rate	Percentile Rank	Absolute Rank
CMS Hospital Compare CHF Quality Score (all patients, 2005)	94	81	344 of 1843
Percent of decedents seeing 10 or more different physicians during the last six months of life	45.3	79	608 of 2892
Total ICU days per decedent during the hospitalization in which death occurred	1.4	60	1440 of 3646
Hospital days per decedent during the hospitalization in which death occurred	2.8	57	1827 of 4271
Deaths by location percent of deaths associated with ICU admission	19.6	54	1674 of 3646
Deaths by location percent of deaths occurring in hospital	35.3	53	1970 of 4271
CMS Hospital Compare Composite Quality Score (all patients, 2005)	86.8	50	905 of 1843
Total ICU days per decedent during the last six months of life	3	50	1791 of 3646
CMS Hospital Compare AMI Quality Score (all patients, 2005)	93.6	50	909 of 1843
Total ICU days per decedent during the last two years of life	5.2	44	2012 of 3646
Hospital days per decedent during the last six months of life	10.9	35	2773 of 4271
CMS Hospital Compare Pneumonia Quality Score (all patients, 2005)	74.8	28	1315 of 1843
Hospital days per decedent during the last two years of life	17.6	24	3225 of 4271

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	-	-
*HRR Average	Baltimore, MD	46,475	22.89	0.86	-107
*HRR Average	Washington, DC	34,921	22.21	0.88	-85
*State Average	Maryland	86,624	21.75	0.9	-70
*National Average	United States	4,732,448	19.98	0.98	-12
Hospital 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	2.78	-	-
*HRR Average	Washington, DC	34,921	3.43	0.81	-2,121
*HRR Average	Baltimore, MD	46,475	3.29	0.84	-1,690
*State Average	Maryland	86,948	3.24	0.86	-1,524
*National Average	United States	4,732,448	2.83	0.98	-166
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	-	-
*HRR Average	Washington, DC	34,921	40.74	0.87	-177
*State Average	Maryland	86,948	37.95	0.93	-86
*HRR Average	Baltimore, MD	46,475	36.86	0.96	-50
*National Average	United States	4,732,448	36.19	0.98	-28

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	-	-
*HRR Average	Baltimore, MD	46,475	4.43	0.67	-4,817
*National Average	United States	4,732,448	3.84	0.77	-2,922
*State Average	Maryland	86,624	3.84	0.77	-2,914
*HRR Average	Washington, DC	34,921	3.42	0.86	-1,522
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	-	-
*HRR Average	Baltimore, MD	46,475	44.87	1.01	14
*State Average	Maryland	86,948	44.72	1.01	19
*HRR Average	Washington, DC	34,921	42.88	1.06	79
*National Average	United States	4,732,448	35.81	1.27	310
Hospital 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	10.91	-	-
*HRR Average	Washington, DC	34,921	14.94	0.73	-13,149
*HRR Average	Baltimore, MD	46,475	14.82	0.74	-12,769
*State Average	Maryland	86,948	14.46	0.75	-11,611
*National Average	United States	4,732,448	14.71	0.8	-9,458

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

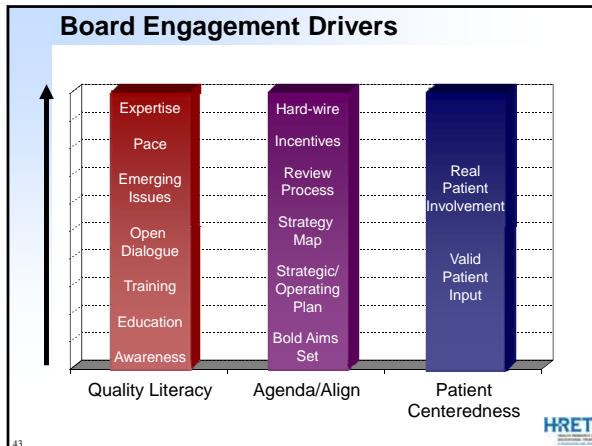
What does the "evidence" tell us about what Boards can do to accelerate improvement?

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.
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- *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.
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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

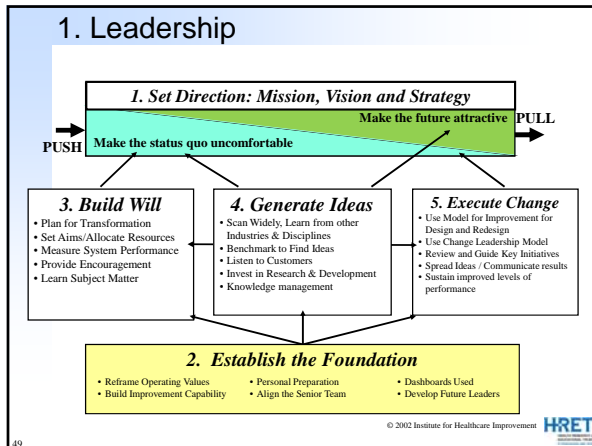


AHRQ Hospital Survey on Patient Safety Culture

- “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/>



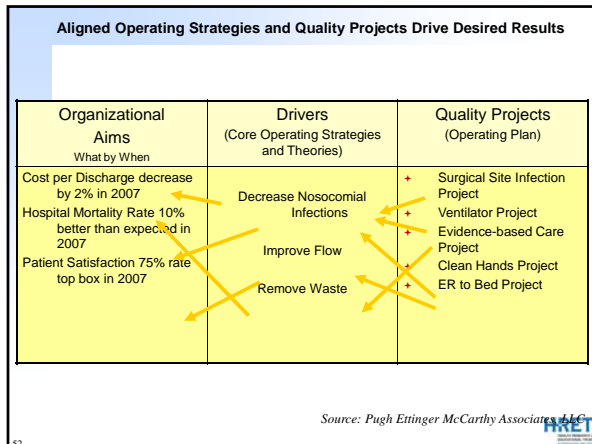


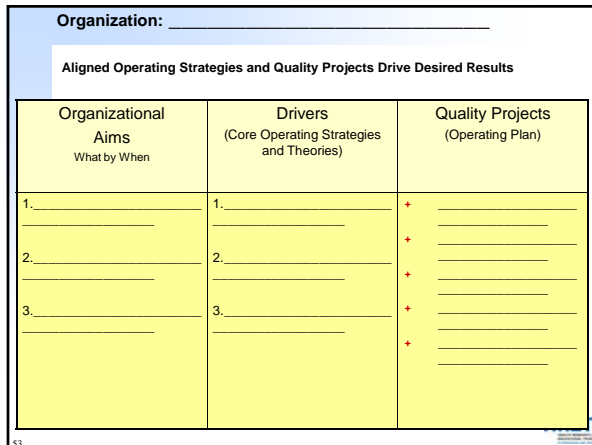
- ### Examples of Big Dots/Outcomes
- | | |
|--|---|
| <ul style="list-style-type: none"> Mortality Readmission Rates Patient Experience % of Patients Receiving Care According to the Evidence (All or none) Harm rate Functional outcomes | <ul style="list-style-type: none"> Employee Satisfaction, Loyalty or Engagement Cost per Discharge Cost per episode Days Cash on Hand Patient Safety Access |
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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"> What are your system level aims and aspirations? What are the system-level measures of those aims? (Big Dots) How good must you be, and by when? 	<ol style="list-style-type: none"> What are your key organizational strategies for moving your dots? What really has to be changed, or put in place, in order to achieve each of these goals? 	<ol style="list-style-type: none"> What set of projects will move the Drivers far enough, fast enough, to achieve your aims?

Source: Pugh Ettinger McCarthy Associates, LLC HRET





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

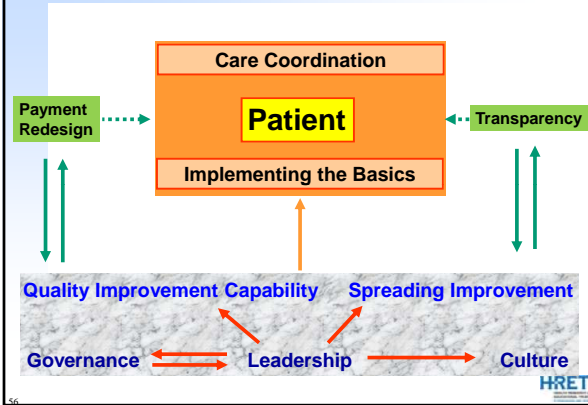
Top Ten Transformers

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

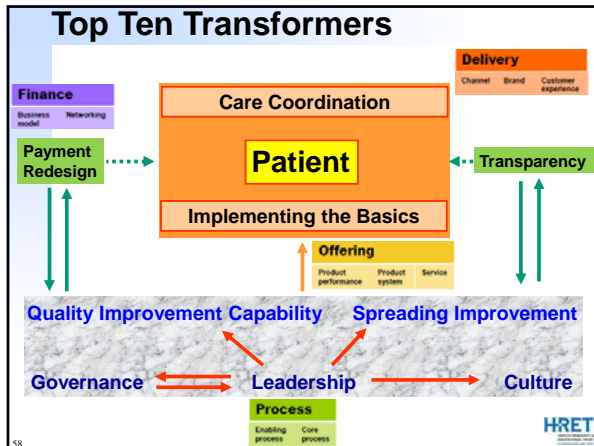


Quality AND Cost

- 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 the authors' names, Maulik S. Joshi, MD and Bernard J. Borak, MD, and a 3D bar chart with four bars in yellow, green, blue, and red. The HRET logo is in the bottom right corner.
