

The Next Imperative for Quality Transparency - Actual Quality Improvement

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The Agenda

- Quality Metrics
- Pay for Performance vs. Pay for Improvement
- Incentives and Future Trends
- Top vs. Average Performers
- Operations - The Simple Stuff
- Operations - The More Complicated Stuff
- What can You Do as a Provider, Health plan, Employer or Consumer?

Quality Transparency

“Whenever you do a thing, act as if all the world were watching”

Thomas Jefferson

Quality Metrics - Categories

□ Outcomes Measures

- Mortality (AHRQ, by patient diag/proc)
- Complications (AHRQ, by patient diag/proc)

□ Process Measures

- Clinical compliance (AMI, HF, Pneu, SIP)
- Operational compliance (wait times, bed placement, nurse staffing)

□ Satisfaction Measures

- Patients (hospital and physician care)
- Physicians, Nurses, Staff

Quality Metrics - Patient Satisfaction

- HCAHPS for Hospitals, first public release was in March 08 for October 06 through June 07
- Two overall ratings and ratings re 8 topics
 - communication with doctors
 - communication with nurses
 - responsiveness of hospital staff
 - cleanliness of hospital environment
 - quietness of hospital environment
 - pain management
 - communication about medicines
 - discharge information
- Complement existing internal hospital surveys

Leading Minnesota Hospitals - HCAHPS

	Park Nicollet	Mayo	UM
Percent of patients who reported that their nurses "Always" communicated well.	71%	82%	67%
Percent of patients who reported that their doctors "Always" communicated well.	77%	83%	71%
Percent of patients who reported that they "Always" received help as soon as they wanted.	56%	71%	50%
Percent of patients who reported that their pain was "Always" well controlled.	64%	74%	58%
Percent of patients who reported that staff "Always" explained about medicines before giving it to them.	55%	63%	50%
Percent of patients who reported that their room and bathroom were "Always" clean.	60%	74%	57%
Percent of patients who reported that the area around their room was "Always" quiet at night.	44%	66%	47%
Percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	78%	87%	82%
Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	63%	75%	55%
Percent of patients who reported YES, they	75%	75%	75%

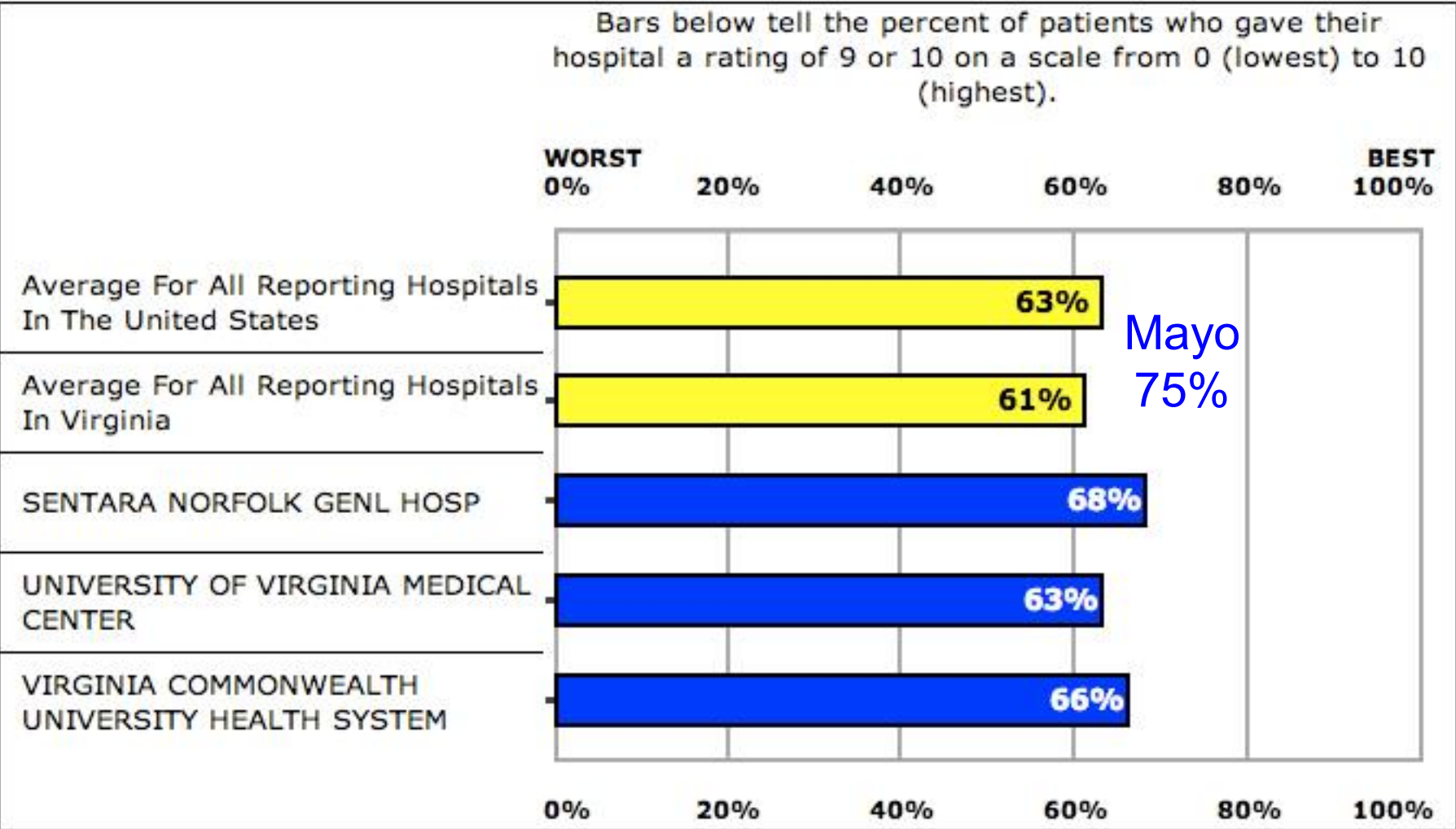
Leading Virginia Hospitals - HCAHPS

	Sentara	UVa	VCU
Percent of patients who reported that their nurses "Always" communicated well.	68%	71%	73%
Percent of patients who reported that their doctors "Always" communicated well.	77%	79%	80%
Percent of patients who reported that they "Always" received help as soon as they needed it.	58%	54%	57%
Percent of patients who reported that their pain was "Always" well controlled.	66%	67%	69%
Percent of patients who reported that staff "Always" explained about medicines before giving it to them.	55%	57%	65%
Percent of patients who reported that their room and bathroom were "Always" clean.	59%	54%	63%
Percent of patients who reported that the noise around their room was "Always" quiet at night.	59%	41%	56%
Percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	82%	84%	85%
Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	68%	63%	66%
Percent of patients who reported YES, they			

Leading Virginia Hospitals - HCAHPS

	CJW	Inova	Lewis-Ga
Percent of patients who reported that their nurses "Always" communicated well.	70%	69%	66%
Percent of patients who reported that their doctors "Always" communicated well.	77%	78%	77%
Percent of patients who reported that they "Always" received help as soon as they wanted.	59%	56%	51%
Percent of patients who reported that their pain was "Always" well controlled.	62%	67%	60%
Percent of patients who reported that staff "Always" explained about medicines before giving it to them.	51%	57%	50%
Percent of patients who reported that their room and bathroom were "Always" clean.	61%	58%	56%
Percent of patients who reported that the noise around their room was "Always" quiet at night.	46%	51%	42%
Percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	79%	77%	80%
Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	64%	64%	63%
Percent of patients who reported that YES, they			

HCAHPS - Overall Hospital Rating #1



HCAHPS - Overall Hospital Rating #2

Bars below tell the percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).

WORST 0% 20% 40% 60% 80% **BEST** 100%

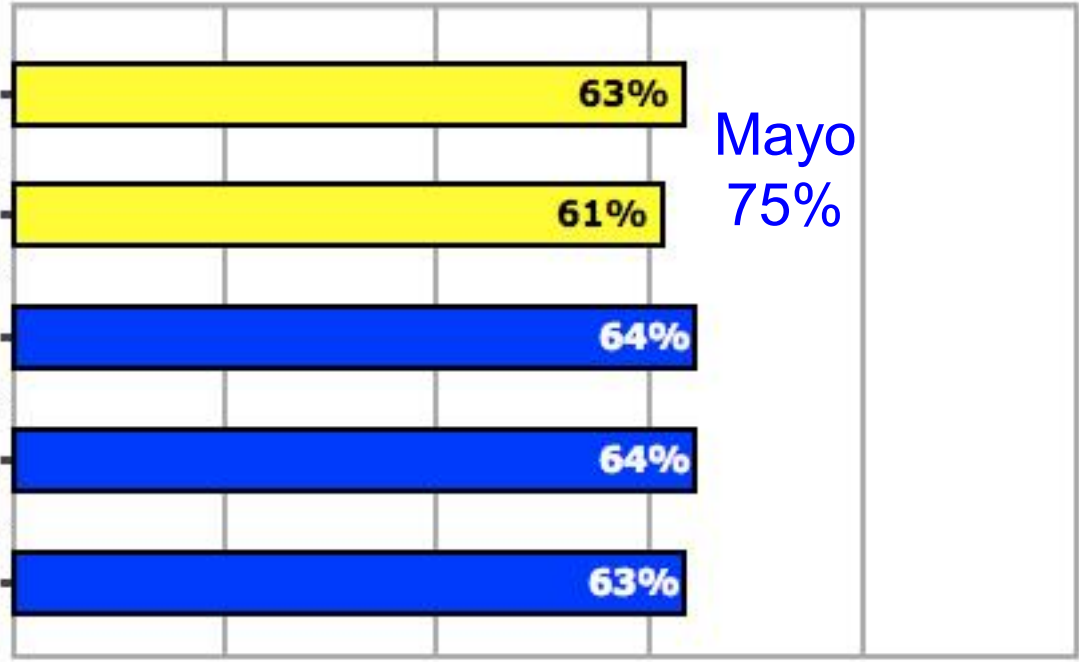
Average For All Reporting Hospitals In The United States

Average For All Reporting Hospitals In Virginia

CJW MEDICAL CENTER

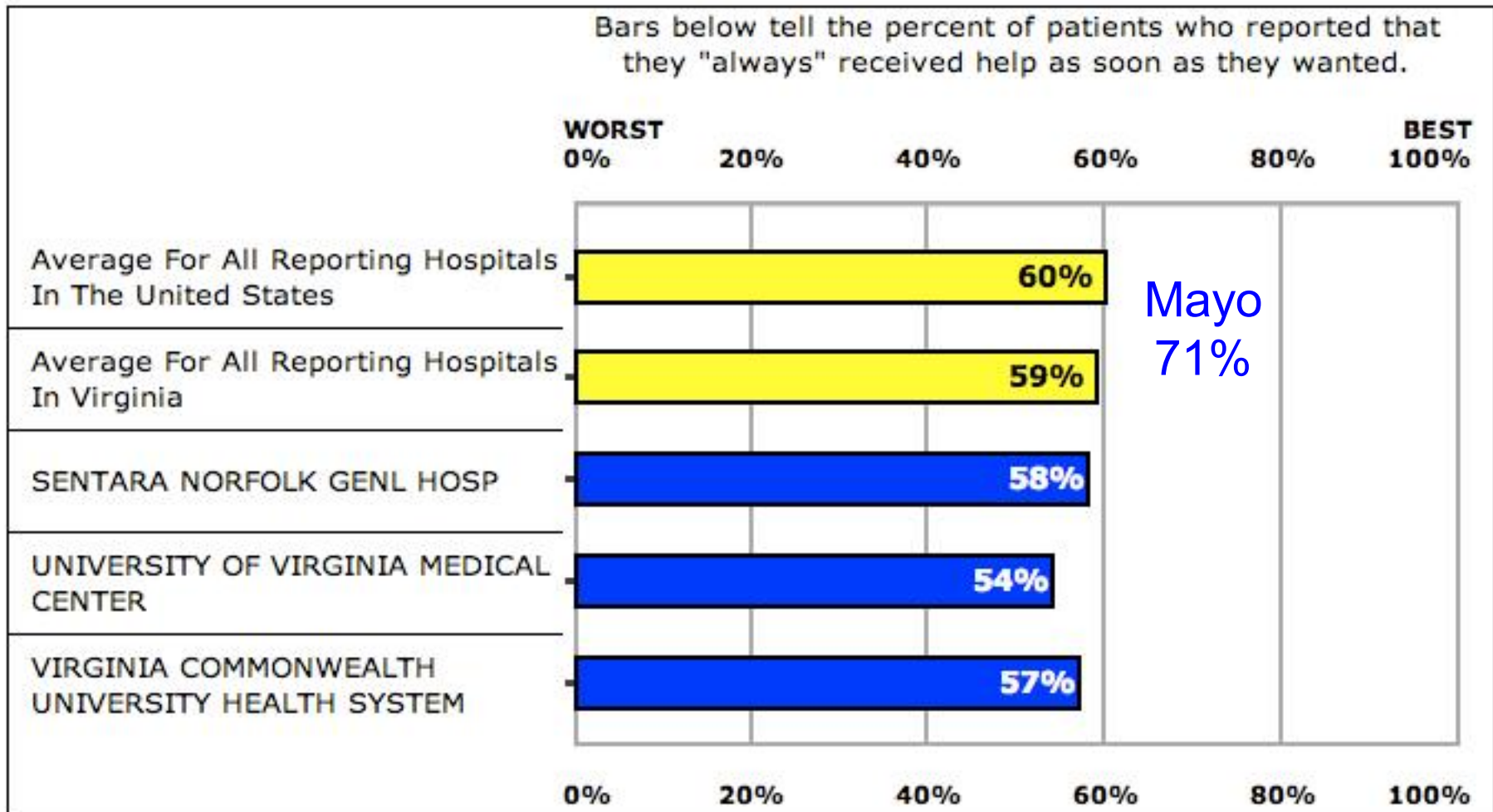
INOVA FAIRFAX HOSPITAL

LEWIS-GALE MEDICAL CENTER



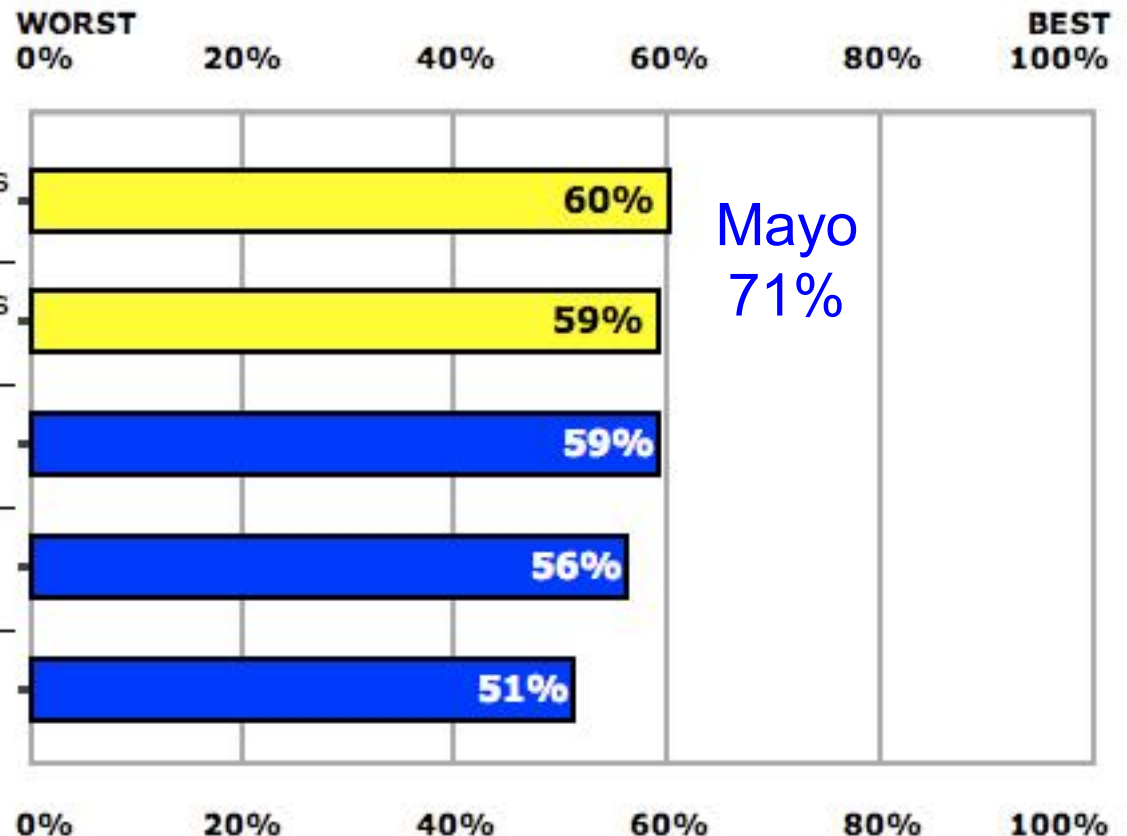
0% 20% 40% 60% 80% 100%

HCAHPS - Help Quickly from Staff #1

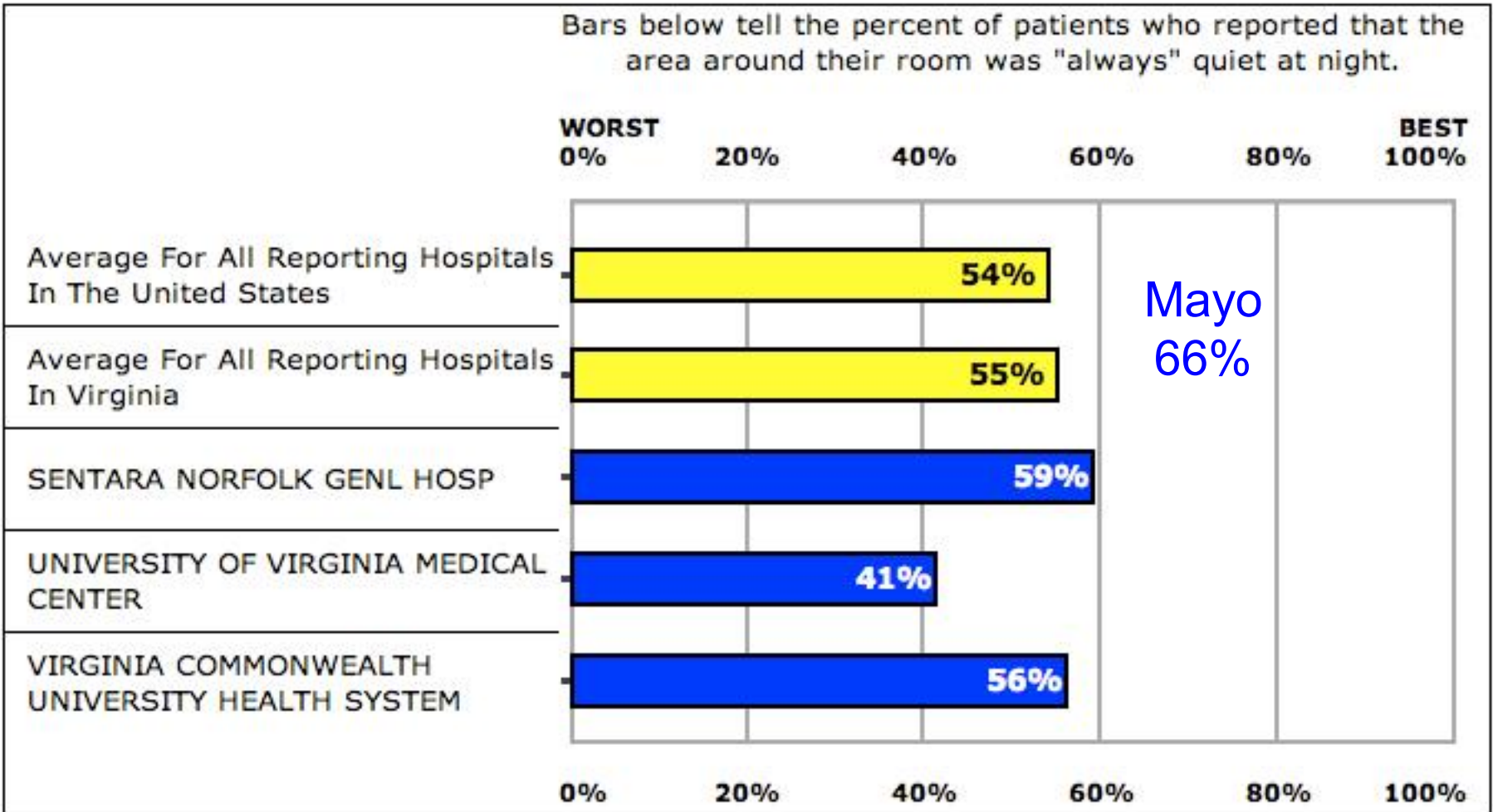


HCAHPS - Help Quickly from Staff #2

Bars below tell the percent of patients who reported that they "always" received help as soon as they wanted.



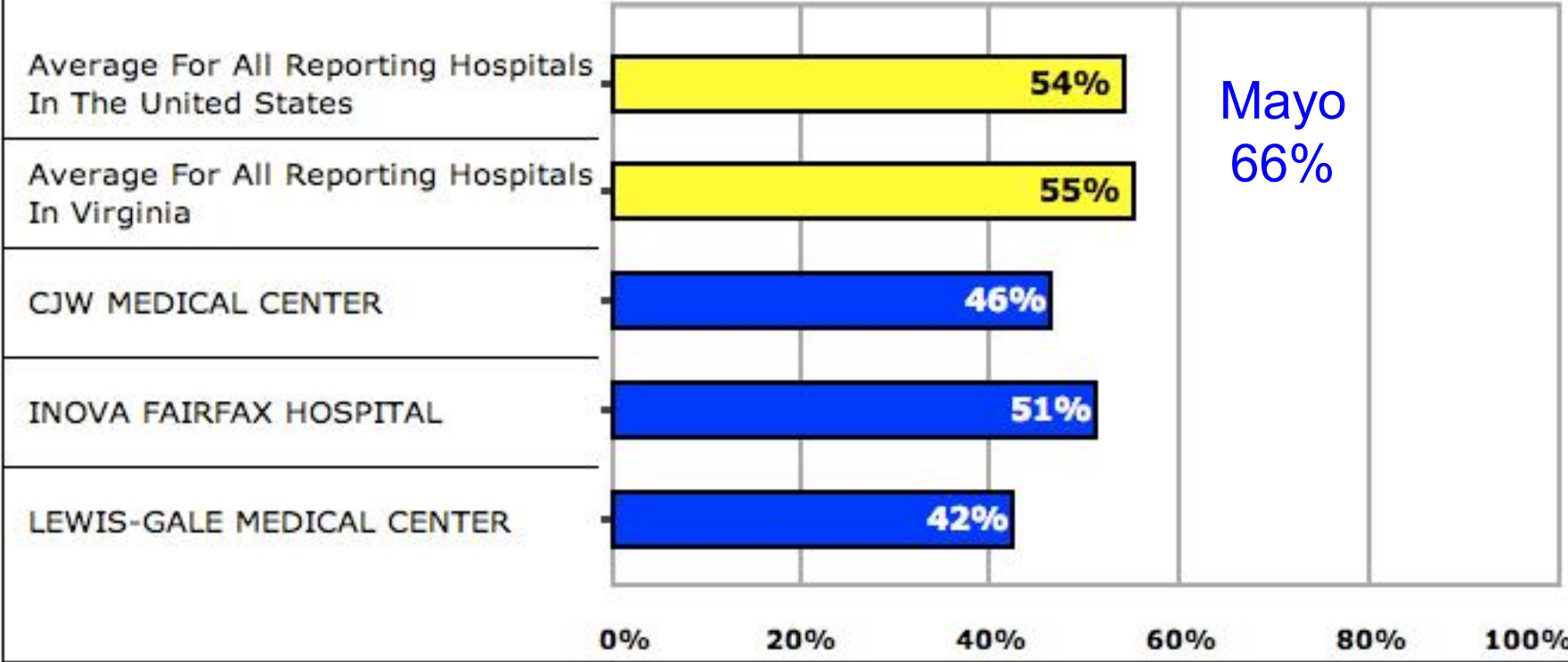
HCAHPS - Quiet at Night #1



HCAHPS - Quiet at Night #2

Bars below tell the percent of patients who reported that the area around their room was "always" quiet at night.

WORST 0% 20% 40% 60% 80% **BEST** 100%



Pay for Performance vs. Pay for Improvement

□ Shortcomings of P4P

- Typically not big enough benefit to trigger major behavior change
- Results to date not compelling, not everyone stands to benefit
- “Teach to the test” problem
- Study at Catholic Health Partners found P4P on CMS measures not any more effective over multi-year period than public reporting and internal incentives (Grossbart, “Effectiveness of Pay for Performance as A Quality Improvement Strategy” in Prescriptions for Excellence in Health Care, Spring 2008)

Pay for Performance vs. Pay for Improvement

□ Benefits of P4I

- Would you rather motivate 80% of the people or 20%?
- Focuses on continual improvement, not just meeting a threshold
- Can have more positive spillover effect than P4P to other quality efforts underway
- More consistent with behaviors of top performing hospitals as discussed later

The Key is Incentives

□ External Incentives

- Meaningful pay for performance (size and target) tied to quality improvement (pay for improvement)
- Public reporting of performance on quality indicators

□ Internal Incentives

- True board oversight of hospital quality goals and objectives
- Executive compensation tied to performance on quality indicators

Some Future Trends to Watch

□ Don't pay for unacceptable performance

- As of 10/1/08, Medicare will not pay for 8 preventable hospital errors including UTI, falls, foreign body left in patient and will be adding 3 more following year
- Private insurers and states following suit

□ Quality Based Payment Systems

- BCBS MA offering contract option for fixed per patient payment (patient health adjusted) plus substantial performance incentives tied to quality, effectiveness and patient satisfaction
- New requirement to implement CPOE to participate in quality and incentive programs

Some Future Trends to Watch

□ Medical Tourism - Global Healthcare Market?

- Bumrungrad International Hospital in Bangkok treats 400k patients from 150 countries/year
- Escorts Heart Institute in New Delhi does over 3,000 CABGs/year (can click on website to request a price)
- Joint Commission International accreditation of 140+ hospitals in 26 countries
- Health plans beginning to actively explore options, especially in relation to small group market
- Anecdotal evidence seems to indicate good quality comes along with substantially lower costs
- Pressure on US hospitals to deliver better quality or lose business overseas?

Top vs. Average Performers

- Study of quality and safety in 79 AMCs through UHC
 - Results reported in Academic Medicine, December 2007
 - What organizational factors are associated with AMCs that stand out from their peers for quality and safety?
 - Performance on patient level outcomes and processes of care (AHRQ mortality, PSIs, JCAHO core measures)
- Conclusion
 - “Distinctive leadership behaviors and organizational practices are associated with measurable differences in patient-level measures of quality and safety”

Common Qualities of Top Performers

□ Shared sense of purpose

- Patient care comes first
- Leaders dissatisfied with status quo
- Service excellence added to focus on quality and safety
- Service, quality, safety as source of competitive advantage

□ Hands-on leadership style

- CEO passionate about service, quality and safety, hands-on
- Alliance between executive leadership and clinical chairs

□ Accountability systems for quality and safety

- Priorities, measures, goals centralized, tactics decentralized
- Accountability, innovation and redundancy at unit level

Common Qualities of Top Performers

□ Focus on results

- Relentless effort to improve vs. external standards
- Results outweigh the approach to performance measurement
- Focus on human behavior and work redesign
- Technology as accelerator, not substitute for work redesign

□ Culture of Collaboration

- Administration, physicians, nurses, staff
- Frequent recognition of employee contributions at every level
- Employees value each other's critical knowledge when problem solving

Commitment to Transparency

□ Beth Israel Deaconess, Boston

- Paul Levy's CEO blog at runningahospital.blogspot.com
- Board commitment by 1/1/2012 to a) eliminate preventable harm and b) to achieve patient satisfaction in the top 2% of all hospitals

THE FACTS AT BIDMC

we're putting ourselves
under a microscope



Why? So *we* can help *you* make informed choices about health care and so we can improve our care when we need to. We believe that putting a public spotlight on ourselves helps us provide the world-class quality care you expect from Beth Israel Deaconess Medical Center.



[Tell Us What You Think]

Why this Info
is Important to

Hospital-wide
Measures

Specific Services
Measures

Our Priorities for
Improvement

Our Awards &
Recognitions

What Our
Patients Say

Focus on Internal Improvement

“We need to re-engineer the production process in healthcare”

Jerome Grossman, MD

New England Medical Center, 1982

The Simple Stuff - Hand Washing

□ The Problem:

- Hand washing compliance 40% to 50% nationwide
- Per CDC, hand washing by providers is single most important factor in preventing hospital infections

□ Some solutions:

- Organizational commitment, observation and incentives allowed Bronson Methodist in Michigan to increase rate from 47% to 94% over 4 years
- Forced function: red light at foot of patient bed that doesn't go off until care provider washes hands (David Nash, MD in Health Policy Newsletter, March 2008)

□ How long would a problem of this magnitude be tolerated outside of health care?

The Simple Stuff - Checklists

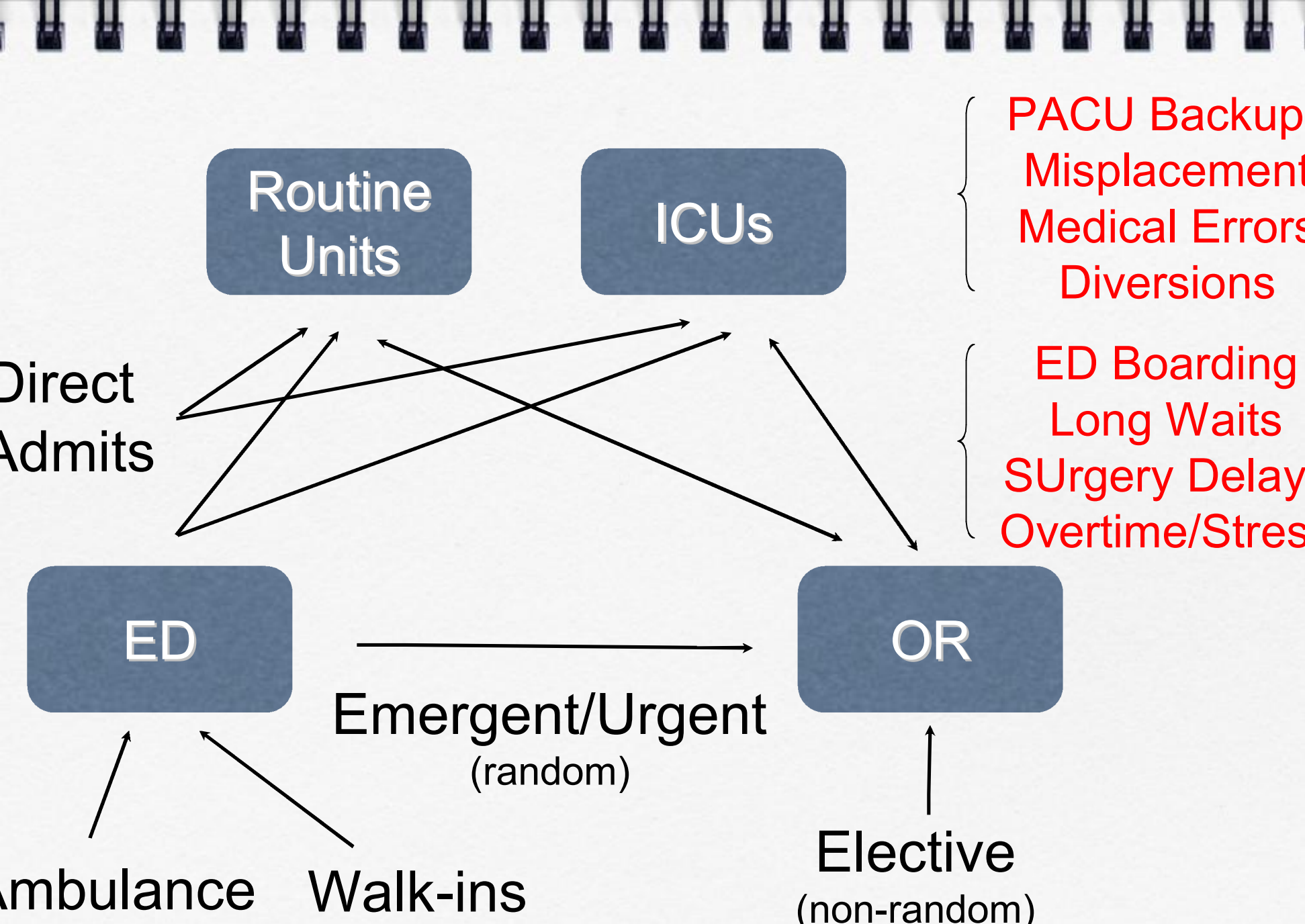
- “THE CHECKLIST: If something so simple can transform intensive care, what else can it do”
 - Article by Atul Gawande, The New Yorker, December 10, 2007, referencing Dr. Peter Pronovost’s work at Johns Hopkins and in Michigan hospital ICUs
 - Keystone Initiative results in Michigan: 66% reduction in ICU infection rate, \$175M savings, 1,500 lives in 18 months
 - “If a new drug were as effective at saving lives as Peter Pronovost’s checklist, there would be a nationwide marketing campaign urging doctors to use it.”
- Aren’t checklists in wide use in some of the safest industries in the world?

More Complicated Stuff - Operations

- **Separate emergent/urgent cases from elective cases in the OR**
 - Apply queuing models to health care
 - Reduce wait times, boarding, medical errors
- **Smooth surgical demand**
 - Develop and apply simulation models to smooth by day of week and destination unit
 - Increase OR capacity, improve patient placement and quality
- **Right size capacity**
 - Identify bottlenecks, model future demand, reallocate existing resources to meet current and projected needs
 - Improve efficiency and effectiveness, reduce capital demands

Institute of Medicine Report - June 2006

- “By **smoothing the inherent peaks and valleys** in patient flow, and eliminating the artificial variabilities that unnecessarily impair patient flow, hospitals can **improve patient safety and quality** while simultaneously **reducing hospital waste and cost.**”
- “Hospital chief executive officers should adopt **enterprise-wide operations management** and related strategies to improve the **quality and efficiency of emergency care.**”



Separation of Competing Flows

□ Random Flow Separation

- 5 items or less line in supermarket
- Express lanes vs. local lanes on highways
- Automated toll collection lanes vs. attended lanes

□ Separation of Random vs. Non-Random Flows

- Walk-ins vs. reservations in restaurant
- Walk-ins vs. appointments for haircut

□ Priority for Random Flows

- First class line vs. coach line for airline check-in
- Triage on the battlefield

Queuing Model Behavior - Examples

- **Status Quo Example (e.g., walk-in clinic)**
 - 1 server, 4 customers per hour (arrival rate), 10 minutes per customer (service rate)
 - What is the average wait time?
- **Add a Second Server**
 - What do you predict will happen to average wait time?
 - What actually happens to average wait time? Why?
- **Increase Arrival Rate to 8 customers/hour**
 - What do you predict will happen to average wait time?
 - What actually happens to average wait time? Why?
 - How many customers handle with wait time < 25 min?

**Scenario
#1**

Model Inputs:

Number of Servers	1
Arrivals per Hour	
1st Priority	4
2nd Priority	
Total Arrivals per Hour	4
Average Service Time (minutes)	10

Model Results:

Average Wait Times:	<u>Minutes</u>
1st Priority	20.0
2nd Priority	0.0
Overall	20.0
Server % Utilization (each server)	66.7%

Queuing Analysis - Hospital OR

Model Inputs:	Scenario #1	Scenario #2	Scenario #3
Case Arrivals per Hour			
"A" cases	0.03	0.03	0.03
"B" cases	0.08	0.08	0.08
"C" cases	0.08	0.08	0.08
"D" cases	0.12	0.12	0.12
"E" cases	0.15	0.15	0.15
Total Arrivals per Hour	0.46	0.46	0.46
Average Case Length (minutes)	100	100	100
Average Turnover Time (minutes)	20	20	20
Total Case Length including TOT	120	120	120

OR Re-engineering Results

Emergent/Urgent
(50% utilization)



Elective
(90% utilization)



OR 1	OR 2
OR 3	OR 4
OR 5	OR 6
OR 7	OR 8
OR 9	OR 10
OR 11	OR 12
OR 13	OR 14
OR 15	OR 16

Overall Utilization increases from 70% to 85%+

Internal Quality Metrics

□ Clinical Compliance

- % wait time compliance (overall, by urgency class)
- Average wait times (overall, by urgency class)
- % patient placement compliance (overall, by service for routine and ICU categories)

□ Operational Compliance

- % cases and case hours during prime time
- ED and PACU boarding, # cases and hours

What Can Providers Do?

- Recognize transparency as a **competitive advantage**, rather than a threat
- Use your **website** as a place to demonstrate your commitment to quality improvement
- Be proactive in emulating the common qualities shared by **top performers**
- Embrace **pay for improvement**
- Adopt the simple and the more complicated **operational changes**
- **Change the production process** of health care

What Can Health Plans Do?

- Move from pay for performance to **pay for improvement**
- Tie **more of provider payment** to quality improvement
- Don't pay for **unacceptable performance** (broaden the list of what is clearly substandard)
- Facilitate/encourage access to **quality and cost information** for consumers and employees
- Get hospitals to focus on operational processes using **operations management theory** to truly change behavior

What Can Employers Do?

- Get your health plans to move from P4P to **P4I**
- Encourage your employees to use **publicly available quality data** to decide on where to go for hospital care
- Take a **more active role** in working with your health plans and area hospitals
- Use **your industry experience** to convince hospitals and physicians that they need to change the production process
- Create the **right incentives** for your employees to be proactive in regards to their health care choices

What Can Consumers Do?

- Continue to **demand transparency** from hospitals, doctors, nurses, health plans, employers
- **Ask about** hand washing, checklists, best practices and even application of operations research
- Talk to your health plan about **not paying for substandard quality**
- **Vote with your feet** by only going to those hospitals and doctors that take transparency very seriously and encourage your friends/relatives to do the same
- Participate on hospital boards, committees, focus groups, etc. and **agitate for change**