

Driving Hospital Quality

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What is Quality?

Some Would Say . . .

- ▶ Clinical Quality (Quality for patients) is the real deal, the “hard stuff.”
- ▶ Service Excellence (Customer service) is the “fluff stuff.”

Does the Patient Experience Affect Quality?

Physician communication correlates STRONGLY with adherence rates by patients in acute and chronic disease. There are now over 100 observational and 20+ experimental studies published demonstrating the correlation of communication (patient satisfaction) with compliance. **Compliance with treatment regimens has significant influence on quality measures in chronic disease and outcomes.**

Medical Care: August 2009 - Volume 47 - Issue 8 - pp 826

- ▶ Patient experience is positively associated with clinical effectiveness and patient safety.
- ▶ Associations appear consistent across a range of disease areas, study designs, settings, population groups and outcome measures
 - ▶ Positive associations 429 studies (77.8%)
 - ▶ No association 127 studies (22%)
 - ▶ Negative association 1 study (0.2%)

Annals of Internal Medicine, May 2006

Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care

▶ John T. Chang, MD, MPH; Ron D. Hays, PhD; Paul G. Shekelle, MD, PhD; Catherine H. MacLean, MD, PhD; David H. Solomon, MD; David B. Reuben, MD; Carol P. Roth, RN, MPH; Caren J. Kamberg, MSPH; John Adams, PhD; Roy T. Young, MD; and Neil S. Wenger, MD, MPH

2 May 2006 | Volume 144 Issue 9 | Pages 665-672

- ▶ (PDFs free after 6 months)
- ▶ Summary for Patients
- ▶ Summary for Patients (PDF)
- ▶ Figures/Tables List
- ▶ Related articles in Annals
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“Better Communication Was Associated with Higher Global Ratings of Health Care”

Setting: 2 managed care organizations.

Patients: Vulnerable older patients identified by brief interviews of a random sample of community-dwelling adults 65 years of age or older who received care in 2 managed care organizations during a 13-month period.

Measurements: Survey questions from the second stage of the Consumer Assessment of Healthcare Providers and Systems program were used to determine patients' global rating of health care and provider communication. A set of 236 quality indicators, defined by the Assessing Care of Vulnerable Elders project, were used to measure technical quality of care given for 22 clinical conditions; 207 quality indicators were evaluated by using data from chart abstraction or patient interview.

Results: Data on the global rating item, communication scale, and technical quality of care score were available for 236 vulnerable older patients. In a multivariate logistic regression model that included patient and clinical factors, better communication was associated with higher global ratings of health care. Technical quality of care was not significantly associated with the global rating of care.

- ▶ Wenger, N. S.
- ▶ Related Articles in PubMed
- ▶ PubMed Citation
- ▶ PubMed

AHRQ Healthcare Quality Domains

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

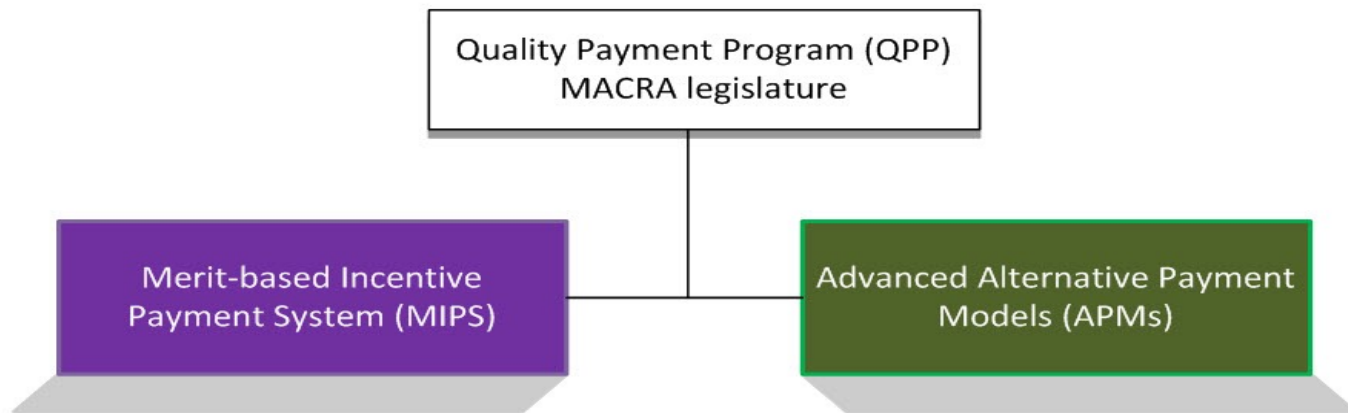
CMS Quality Measures Domains

The 6 NQS domains are:

1. Patient Safety
2. Patient and Family Engagement
3. Care Coordination
4. Clinical Processes/Effectiveness
5. Population/Public Health
6. Efficient Use of Healthcare Resources

Another Way To Say That

1. Making care safer by **reducing harm** caused in the delivery of care.
2. Ensuring that each person and family are **engaged** as partners in their care.
3. Promoting effective communication and **coordination of care**.
4. Promoting the **most effective treatment** and prevention practices for the leading causes of mortality starting with cardiovascular disease.
5. Working with **communities** to promote best practices to enable healthy living.
6. Making quality care **more affordable** for families, individuals, employees, and government by developing and spreading new health care delivery models.



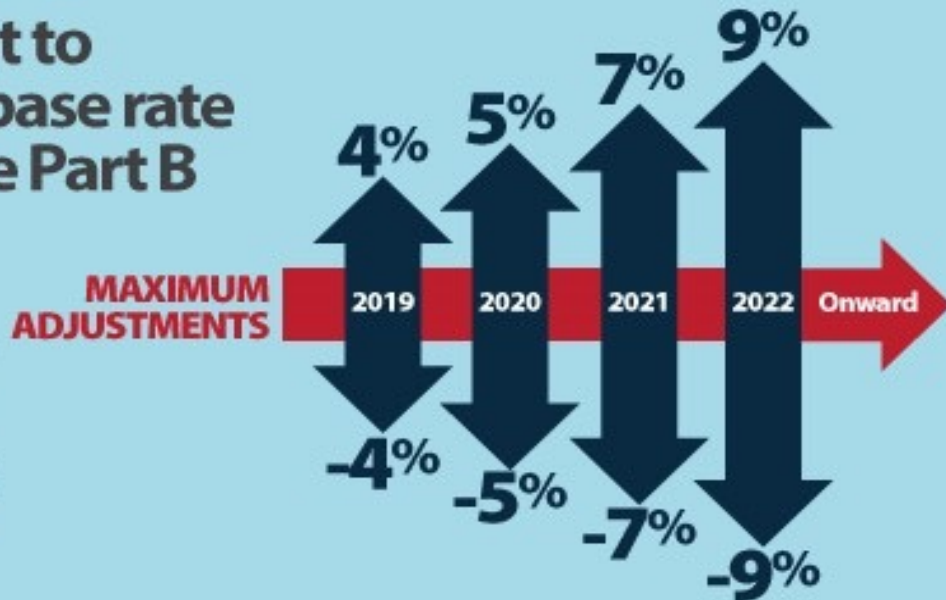
- Eligible clinicians report on four performance categories to determine their payment adjustment.
- Participants
 - Physicians
 - Physician Assistants
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetists

- Eligible clinicians who are part of an Advanced APM designated by CMS receive a 5% bonus incentive payment
- Advanced APMs
 - CPC+
 - MSSP Track 2 / 3
 - Next Gen ACO
 - Comprehensive ESRD Care (CEC)

MIPS

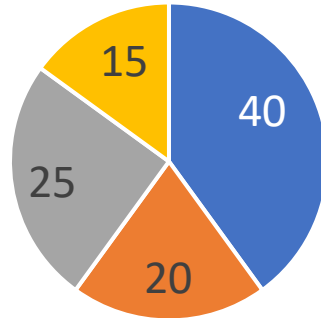
(Merit-Based Incentive Payment System)

Adjustment to
provider's base rate
of Medicare Part B
payment

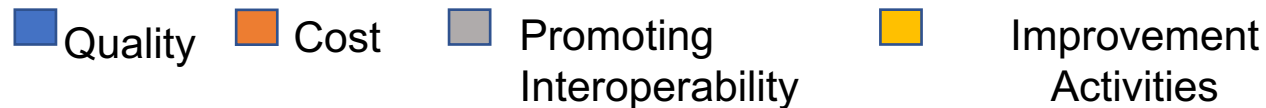
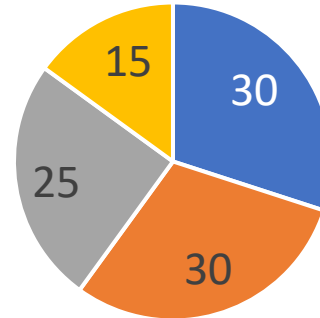


MIPS Scoring in 2023

2023 Payment
Year
(2021 Perf Year)



2024 Payment
Year*
(2022 Perf Year)



<https://mdinteractive.com/mips-blog/cms-releases-2022-mips-final-rule-key-takeaways>



Emergency Care Quality Measure Consortium

ECQMC is an industry-leading coalition founded by ACEP in 2019.

Vision

The goal of the Emergency Care Quality Measure Consortium (ECQMC) is to improve the quality, safety, and transparency of emergency care by ensuring the development of meaningful measures that will improve patient outcomes and reduce costs. Further, by promoting quality measure alignment across emergency medicine, ECQMC will help reduce the burden of measurement and will improve the efficiency of measure development and maintenance.

Why join ECQMC?

Emergency medicine (EM) is underrepresented within quality measurement, as there are currently only a few measures that are truly meaningful for EM clinicians. Each year that short list of existing EM measures gets even shorter, as measures are “topped out” and eliminated. There is most definitely an urgent need to develop new meaningful EM measures, and ECQMC represents a great opportunity to take the driver’s seat in that effort. By becoming a member of

<https://www.acep.org/contentassets/b2d2871448b64c23985b6f1853ccb077/ecqmc-flyer .pdf>

E-QUAL Mission:

“Engage emergency
clinicians and leverage
emergency departments
to improve clinical
outcomes, coordination
of care and to reduce
costs”



Home Page

Home

What's New

Executive Insight

Quick links: [Current News](#) | [Background](#) | [About the Survey](#) | [New Communication About Pain Composite Measure Released](#) | [CMS Presentation on the HCAHPS Survey](#) | [Opioid Misuse](#) | [Commentary on the HCAHPS Survey and Opioid Misuse](#) | [HCAHPS Publications by the HCAHPS Project Team](#) | [Participation](#) | [For More Information](#) | [Provide Comments or Questions](#) | [Internet Citation](#)

Public reporting will include the following
(as well as the two overall ratings):

- Communication with Doctors
- Communication with Nurses
- Responsiveness of Hospital Staff
- Care transition
- Communication about Medicines
- Cleanliness and Quiet of Physical Environment
- Discharge Information

Each Domain consists of 2-3 questions

During your hospital stay, how often did doctors/nurses:

- ▶ ***treat you with courtesy and respect?***
- ▶ ***listen carefully to you?***
- ▶ ***explain things in a way you could understand?***

Never/Sometimes/Usually/Always

ED PEC Survey, renamed ED CAHPS

- <https://www.cms.gov/files/document/ed-cahps-10-2-column-survey-english-july-2020.pdf>
- Is not mandatory and no plans to make it so
- 24 questions about care received
- 9 demographic questions
- No questions on pain
- Several questions on follow-up

The ED Global Rating Question

23. Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate this emergency room visit?

0 Worst care possible

1

2

3

4

5

6

7

8

9

10 Best care possible



Real-Time Analysis

53rd percentile

☆ Favorite ▾

📧 Subscribe

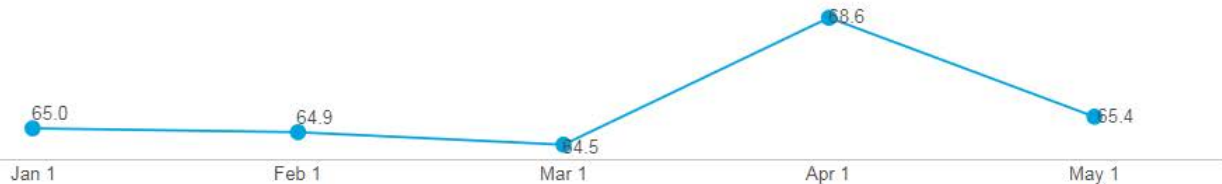
📄 Export ▾

Jan 01, 2019 - May 04, 2019 📅

OVERALL RATING

65.8

(n=6,541)



Emergency  65.8

 6,541

Patient Score

n-size

Real-Time Analysis

75th percentile

☆ Favorite ▾

📧 Subscribe

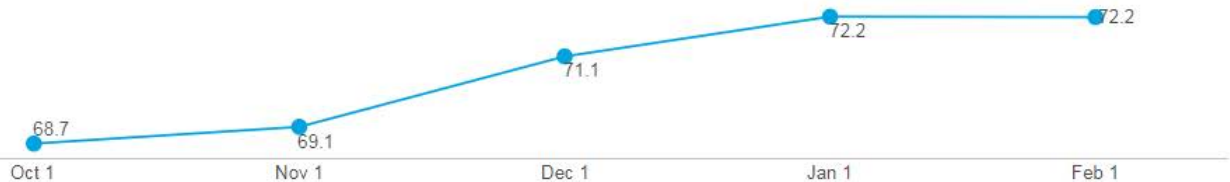
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Oct 01, 2019 - Feb 04, 2020 📅

OVERALL RATING

70.3

(n=6,862)



Emergency  70.3

 6,862

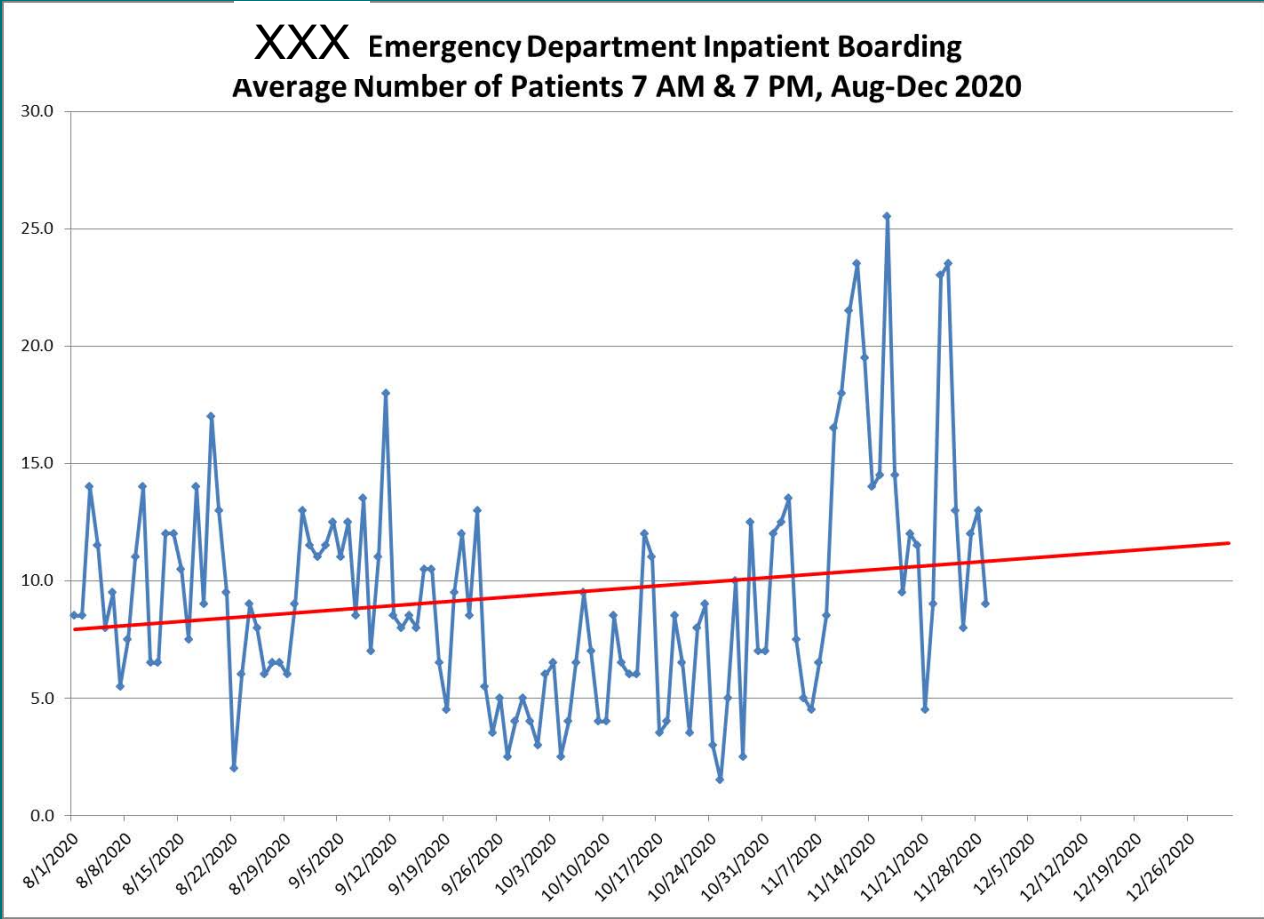
Patient Score

n-size

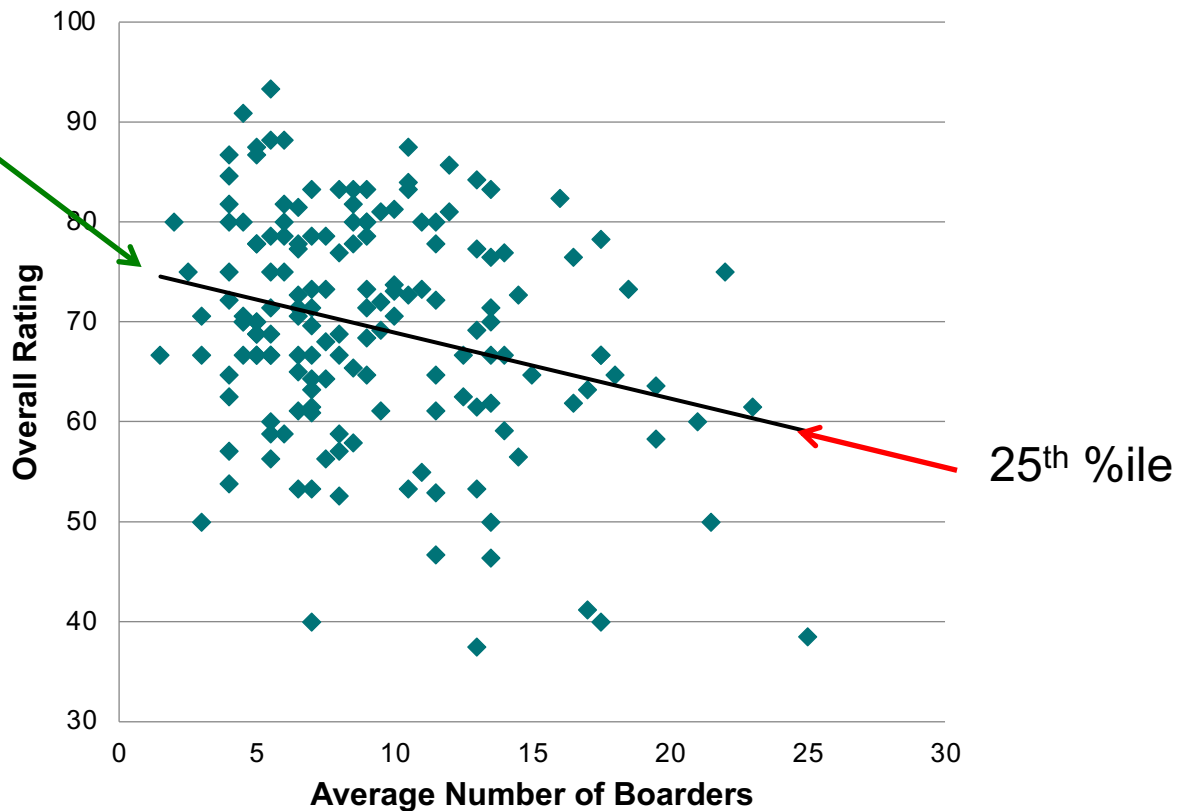
Boarding week of November 23-29, 2020

Date	Time	A	B	C	D	E
11/23/2020	7:00 AM	20	5	0	0	1
11/23/2020	7:00 PM	26	14	3	1	0
11/24/2020	7:00 AM	31	4	1	0	0
11/24/2020	7:00 PM	16	10	3	1	1
11/25/2020	7:00 AM	16	7	0	0	0
11/25/2020	7:00 PM	10	10	4	3	0
11/26/2020	7:00 AM	7	5	1	1	0
11/26/2020	7:00 PM	9	5	4	0	0
11/27/2020	7:00 AM	12	7	1	0	0
11/27/2020	7:00 PM	12	11	1	0	0
11/28/2020	7:00 AM	19	4	1	0	0
11/28/2020	7:00 PM	7	9	2	2	1
11/29/2020	7:00 AM	10	6	0	0	1
11/29/2020	7:00 PM	8	8	0	2	0
Daily #		14.5	7.5	1.5	0.7	0.3
Daily # last week		12.4	7.7	1.5	2.4	0.6

Boarding graphs for each facility



Boarding Effect on Patient Experience



**Correlation
of Boarding
&
ED Patient
Experience**

82nd %ile

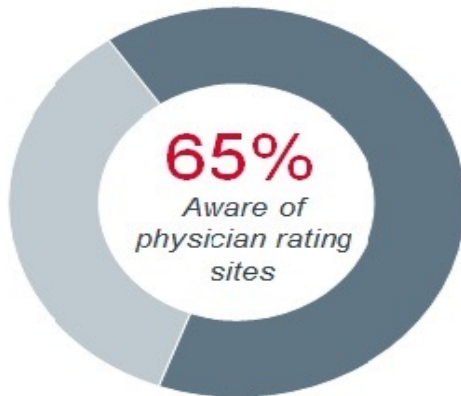
25th %ile

Online Patient Exp. Ratings Driving Physician Selection

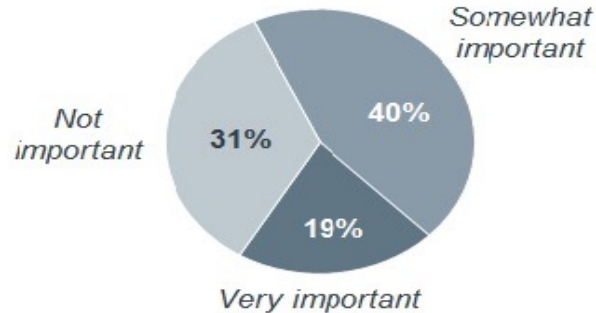
2014 JAMA Study Findings

N = 2,137

Patients Know About
Online Rating Sites...



...Find Ratings Important
When Choosing a Provider...



...And Make Decisions
Based on Reviews

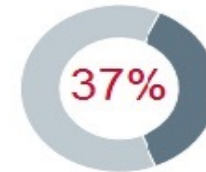
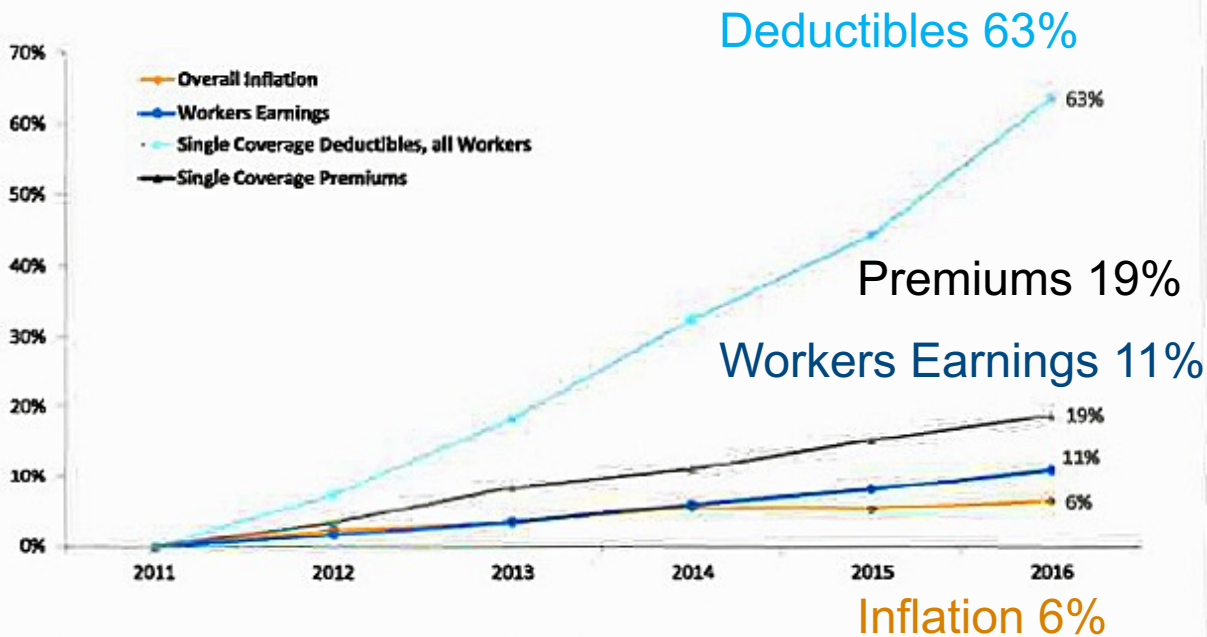


Figure 4

Cumulative Increases in Health Insurance Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2011-2016



NOTE: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2011-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2016 (April to April).



High Deductible Insurance Plans

The New Paradigm

**Exceptional
Clinical Quality
Outcomes** =

Income

**Extraordinary
Patient Experience**

The Definition of Quality in Emergency Medicine Has Changed . . .

- ▼ Reduce avoidable admissions
- ▼ Reduce re-admissions
- ▼ Reduce unnecessary testing
- ▼ Improving patient cycle-time (reduce time off from work, reduced pain and anxiety, etc..)
- ▼ ED no longer to “Door to the Hospital” → now the “Porch of the Medical Neighborhood”

Can We Change the SOP from . . . ?

“I’m going to do it my way.”

to

“We’re going to do it our way.”

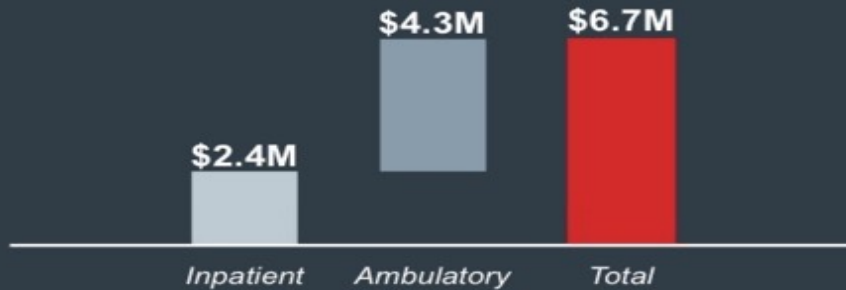
(Become more consistent and reliable in our delivery of care → the catch phrases: “High Reliability Organization” and “Zero Preventable Harm”)

Cracking the Code on Clinical Decision Support

Nearly \$14M Captured in Cost Savings and Risk-based Payments From Scaling Adherence to Guidelines

Reduce Costs

Annual Cost Savings at Cedars-Sinai



Generate Returns

2015 Anthem ACO Payments Received



Improve

36%

Decrease mortalities

Improved Outcomes

36% decrease mortality, 33% decrease readmission

\$6.7 million cost savings, \$7.2 million ACO payments

day readmissions

Admissions/1,000

\$/MG²

Strategies to Improve Quality

▼ Pro-Active

- ▼ Leader/Physician Rounding

- ▼ Dashboard/Action Plan

- ▼ Discharge Follow-Up Phone Calls

▼ PI/Six Sigma/Lean

▼ Retrospective

- ▼ Systems Metrics

- ▼ Quality Assurance

- ▼ Clinical Compliance

Rounding in the ED

- ▶ Nurse Leader round each shift on employees
- ▶ MD Leader round once weekly on MDs and patients, connecting the dots
- ▶ Clinical Leaders round every 4 hours on patients and staff, connecting the dots
- ▶ Technical staff round frequently at discretion of Charge RN to do “comfort rounds”
- ▶ Rounding in reception area (decrease your LNS)

Key Tactic: Leader Rounding on Staff

▼ Harvest Wins:

“Are there any individuals or physicians you would like me to compliment or recognize?”

▼ Focus on the Positive:

“What is going well today?”

▼ Identify Process Improvement Areas:

“What systems can be working better?”

▼ Repair and Monitor Systems

“Do you have the tools and equipment to do your job?”

▼ Coach on Behavior/Performance Standards

“Our focus for the day is __. Can you do that?”

Verifying Behaviors: Leader Rounding on Patients

LEADER ROUNDING LOG

De Pa Re Ex Go ca Do Do ke Ha Do	<p>Good morning. My name is _____. I am medical/nursing director of _____. I am just stopping by because we put our patients First, and our goal is to give you exceptional care. Would you be willing to share your experience in the hospital with me?</p>	
		<p>y staff and I are doing everything we e been any delays? Have you been</p>
	<p>You may receive a survey in the mail after you go home. we would appreciate if it you would fill it out. The survey lets us know how we are doing and if we are providing our goal of "very good" care. We also want to use it to reward and recognize staff.</p>	

Talk to your staff before & after rounding. Forward log sheets to your senior manager each week.

Room #	Notes: Behavior Recognized	Reward (R) or Coach (C) Opportunity	Staff member to Reward or Coach.

Date: _____ Physician Rounded with: _____ Rounder: _____

	Behaviors Observed:	Patient #1	Patient #2	Patient #3
<u>Relationship</u>	Acknowledge Connect with the patient <u>and</u> the family?	<u>Comments</u>	<u>Comments</u>	<u>Comments</u>

Shadow Rounding with Staff/Providers

	State your name and your role? Highlight your skill and expertise? Mentorship opportunities?			
	Recommendations:	Coaching Other Skills: Rounding Follow-up Phone Calls		

Acknowledge

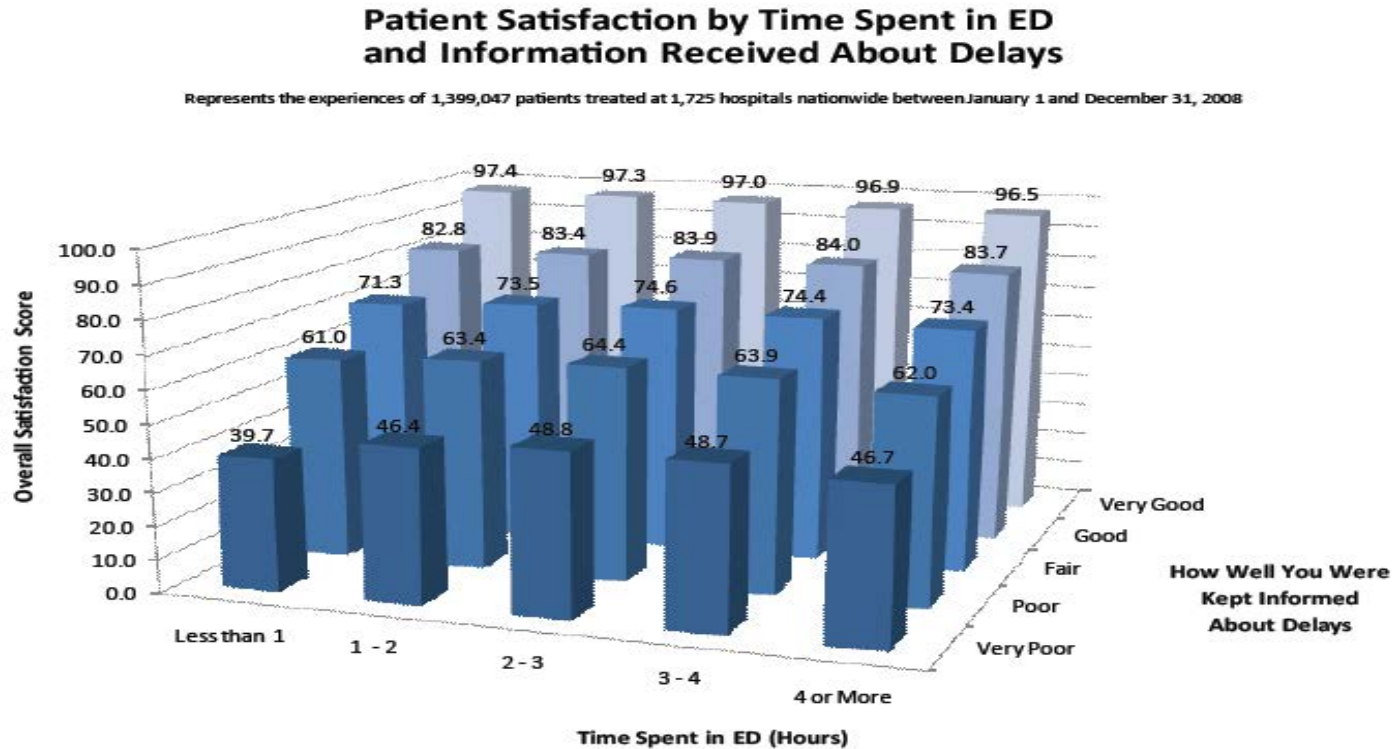
Did you connect with the patient and the family?

Did you make eye contact, shake hands or make physical contact? Any non-medical connection? Did you sit down at the bedside?

Key Tactic: Rounding on Patients by Physicians

- Touch base with your patients at least every 30 minutes
- Do not wait for all diagnostic study results to return to touch base with your patients
- Address PPD – Pain, Plan of Care and Duration
- Assess additional comfort needs. (*warm blanket, pillow*)
- If you get a bolus of patients in at one time, pollinate the rooms – tell patients you know they are there.
- If the reception area gets unruly, go out and quiet it down (takes 30 seconds).

Patient Perception → Quality



Your Action Plan

Pillar of Excellence	90-Day Goal	Action Steps	Responsible Person(s)	Due Date	*	Results
Service						
Raise ED Pat. Sat. to 85%	Raise ED Pat. Sat. to 40%	<u>Rounding</u>	Carol, Marilyn, Lauri, Joan			Quarterly PG Report shows 18% Pat Sat
		- Create a schedule to Round ALL ED Patients every 3 hours.		20-Sep		Schedule includes Marilyn, Joan, Carol and select Charge Nurses
		- Follow schedule and Round every day.		20-Sep		Rounding taking place every day; Medical Director, Dr. M also rounding when not on duty.
		- Mentor certain Charge Nurses to begin Rounding.	Marilyn, Joan	15-Oct		Charge nurses being
Call 100% of eligible discharged patients.	Call 30% within 24 hours of discharge.	<u>Make and Track Discharge Phone Calls</u>				
		- Matthew testing call and documentation process.				
		- Receive update from Matthew.	Joan, Matthew	20-Sep		Follow up calls being done daily. Matthew has created a data base and reports are generated as calls are made. Reports posted for staff.
		- Organize the process (Prepare List of Patients, Distribute among team, Prepare Tracking Log). Select team to make discharge calls everyday.	Joan, Matthew, Bree, Marilyn, Carol, Mary	15-Oct		Calls being made using the charts. Will explore using a printout of patients from HBOC Star.
		-Log number of calls made, list compliments and concerns received, provide feedback to staff daily.	Discharge Team	7-Oct		Reports generated from callers posted

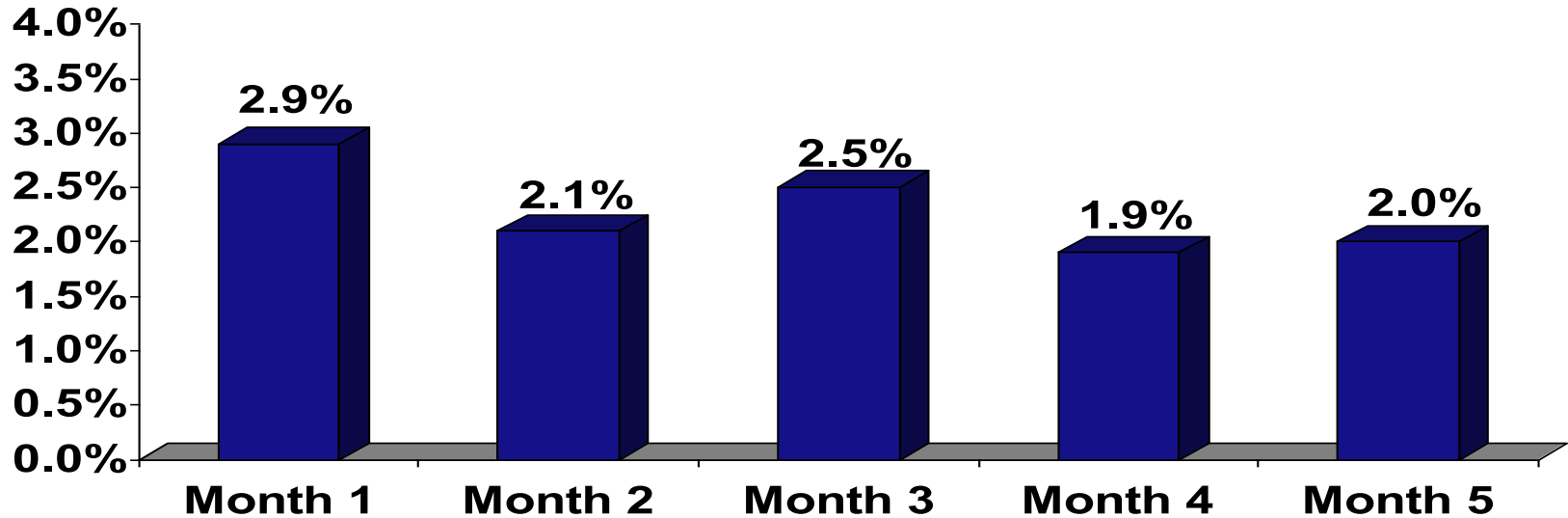
How To Complete the Patient Experience: Follow Up Phone Calls

Engel K, Heisler M, Smith D, Robinson C, Forman J, Ubel P, "Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware When They Do Not Understand?," *Annals of Emergency Medicine*. July 11, 2008

- 78% did not have full understanding
- 80% of that 78% did not understand that they did not understand

Discharge Calls: Improved Clinical Quality

**Emergency Department:
Volume Adjusted 24-hour Emergency Department Returns**

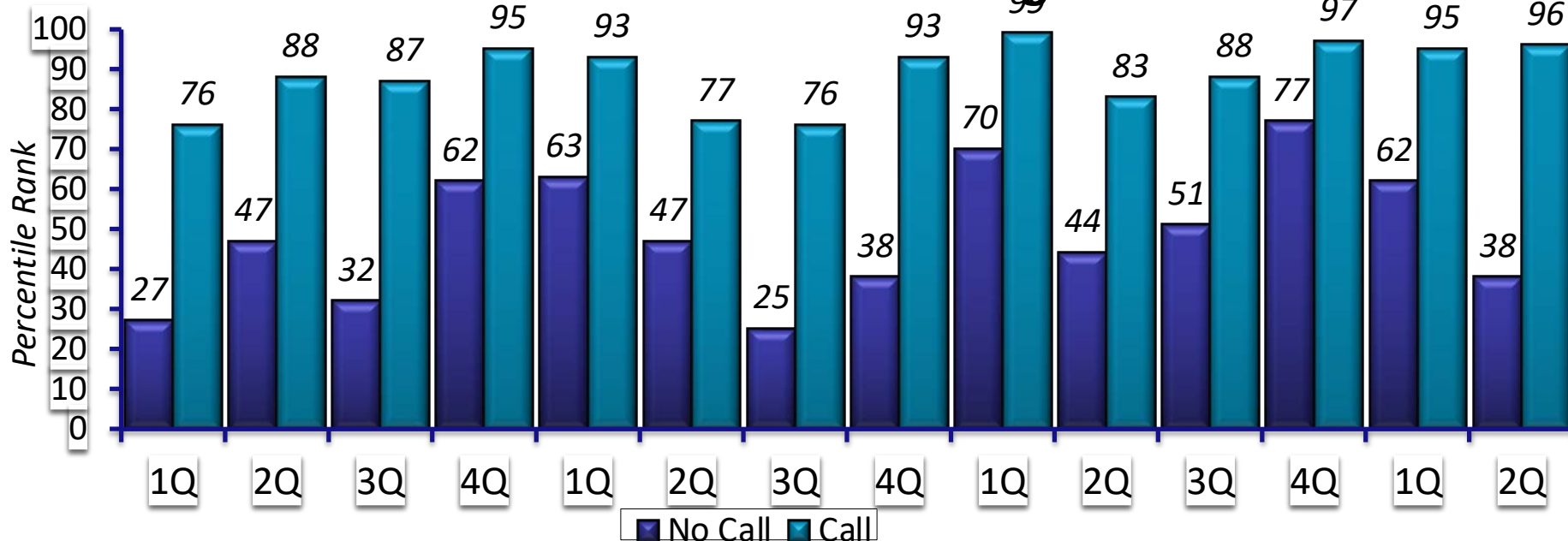


Source: *The Regional Medical Center, South Carolina, Total beds = 286*

Post Visit Calls

Likelihood of Recommending - ED

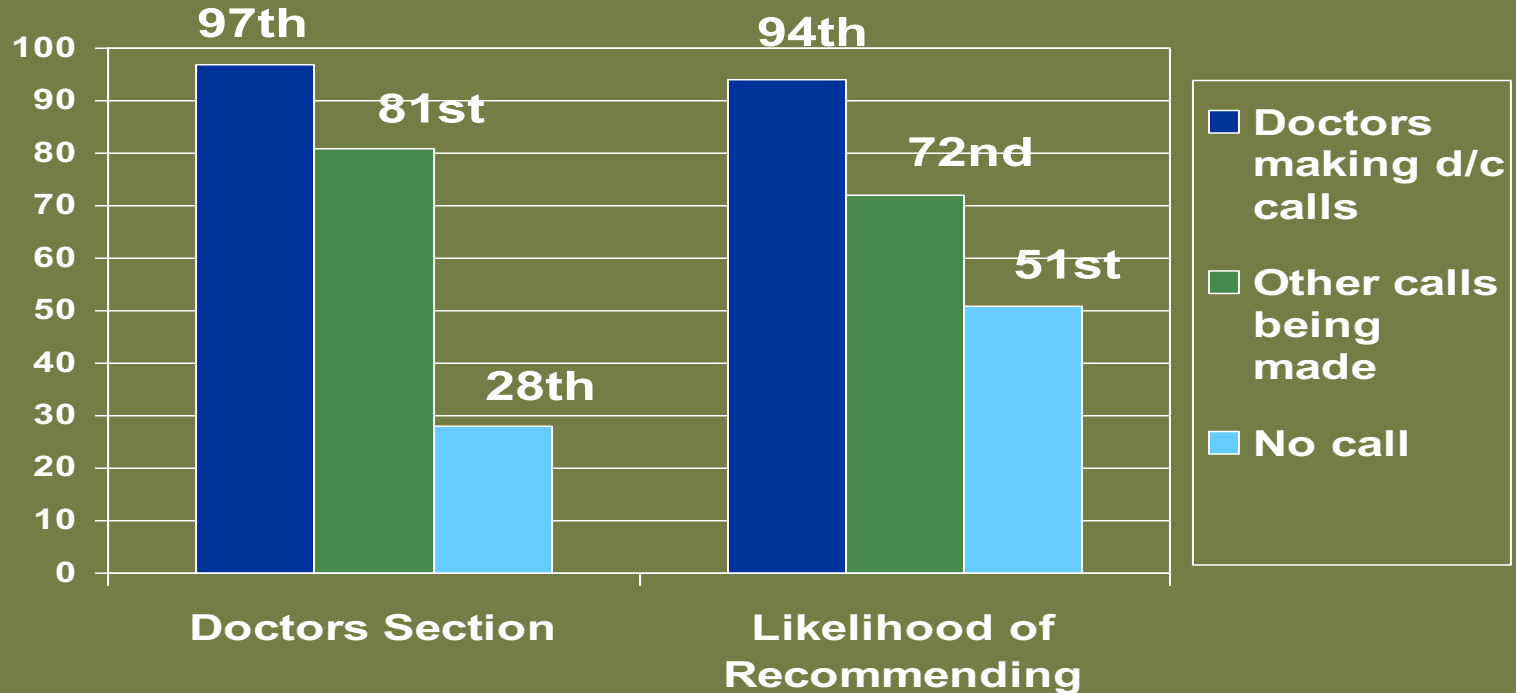
Likelihood of Recommending - ED



Source: New Jersey Hospital, Total beds = 775; 3Q2007 - 2Q2010

Improves Physician Performance...

(January-June 2008, Press Ganey National %tile rank)



**Shaping
& Sharing**

SUCCESSFUL
HEALTHCARE
OUTCOMES

Follow Phone Calls: 6 Reasons Why

- ▼ Quality
- ▼ Risk management
- ▼ Patients love it
- ▼ You will love it (lots of kudos)
- ▼ You will be a better clinician
- ▼ Decreased return visits/hospital admissions

**The Power of the
Follow-Up Phone Call**



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Emergency Department (504) 702-4003

Personal Voicemail (504) 894-5223

Jay.Kaplan@LCMHealth.org

2000 Canal Street
New Orleans, LA 70112
www.UMCNO.org

At the University Medical Center Emergency Department
we are genuinely concerned about
your health and your comfort.

We commit to keeping you informed about your care.

Our mission is to care for you in an outstanding
and compassionate way, answer your questions, and explain
all procedures and treatments.

Our goal is to provide you with exceptional care
and extraordinary service.

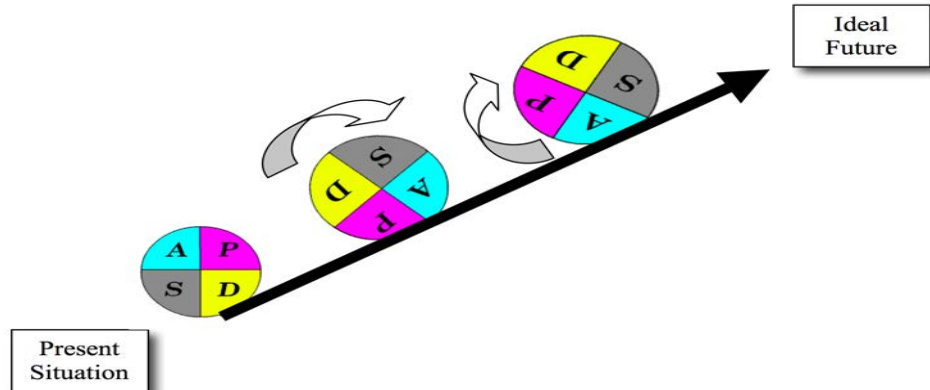
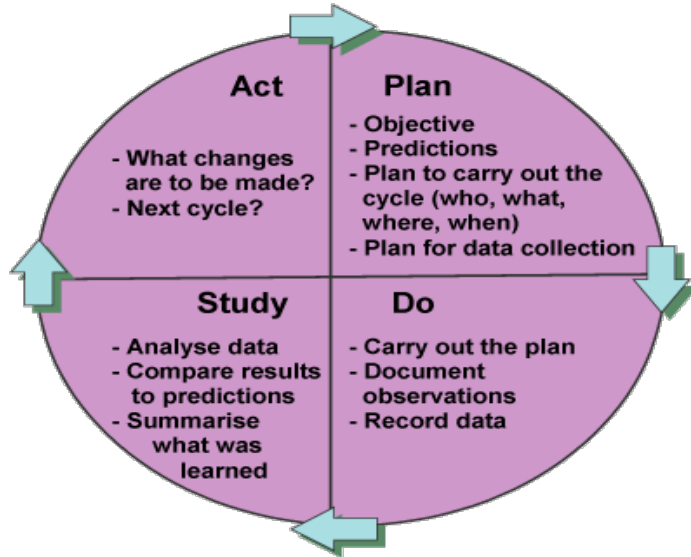
Thank you for giving us the privilege of caring for you.

Strategies to Improve Quality

- ▼ Pro-Active
 - ▼ Leader/Physician Rounding
 - ▼ Dashboard/Action Plan
 - ▼ Discharge Follow-Up Phone Calls
- ▼ **PI/Six Sigma/Lean**
- ▼ Retrospective
 - ▼ Systems Metrics
 - ▼ Quality Assurance
 - ▼ Clinical Compliance

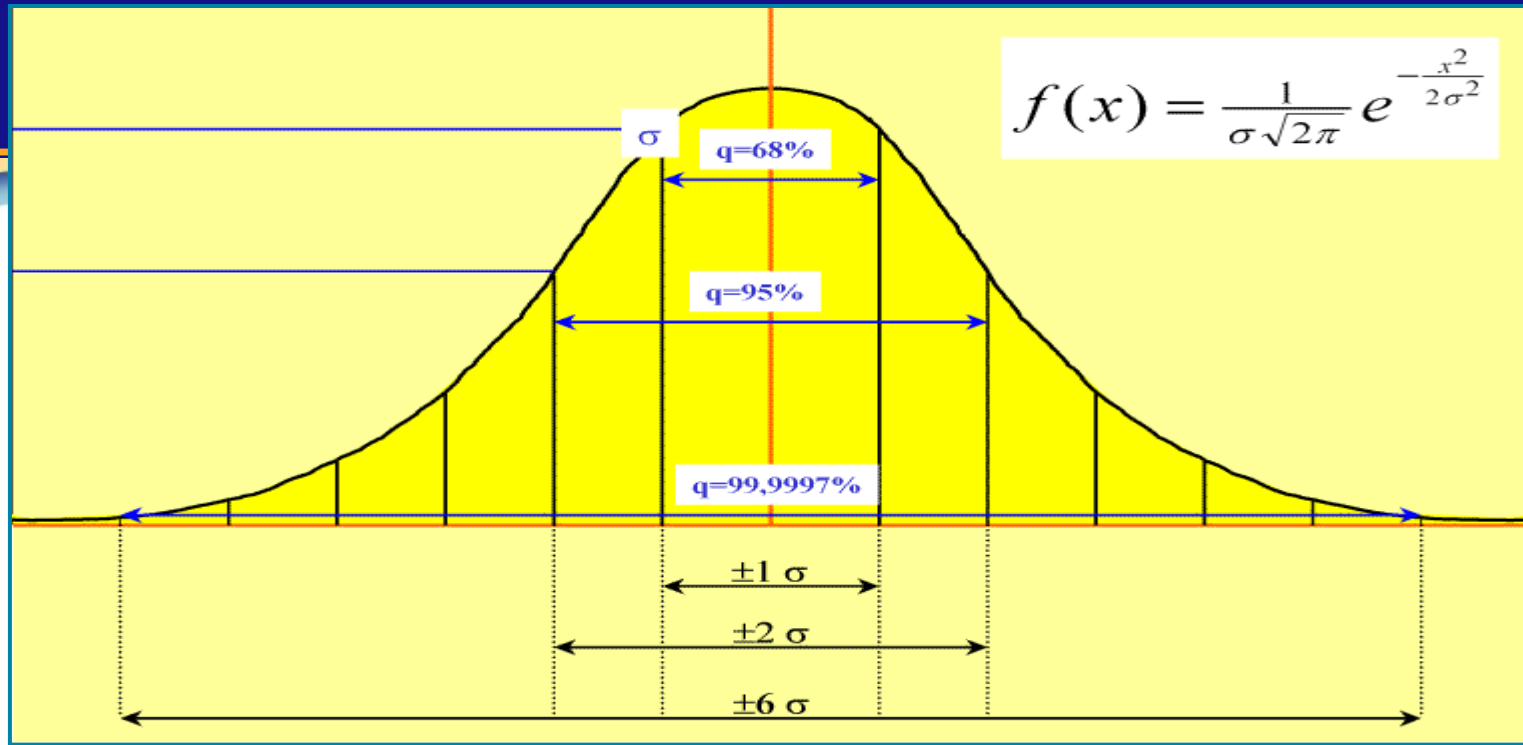
Performance Improvement

The PDSA Cycle for Improvement



Six Sigma



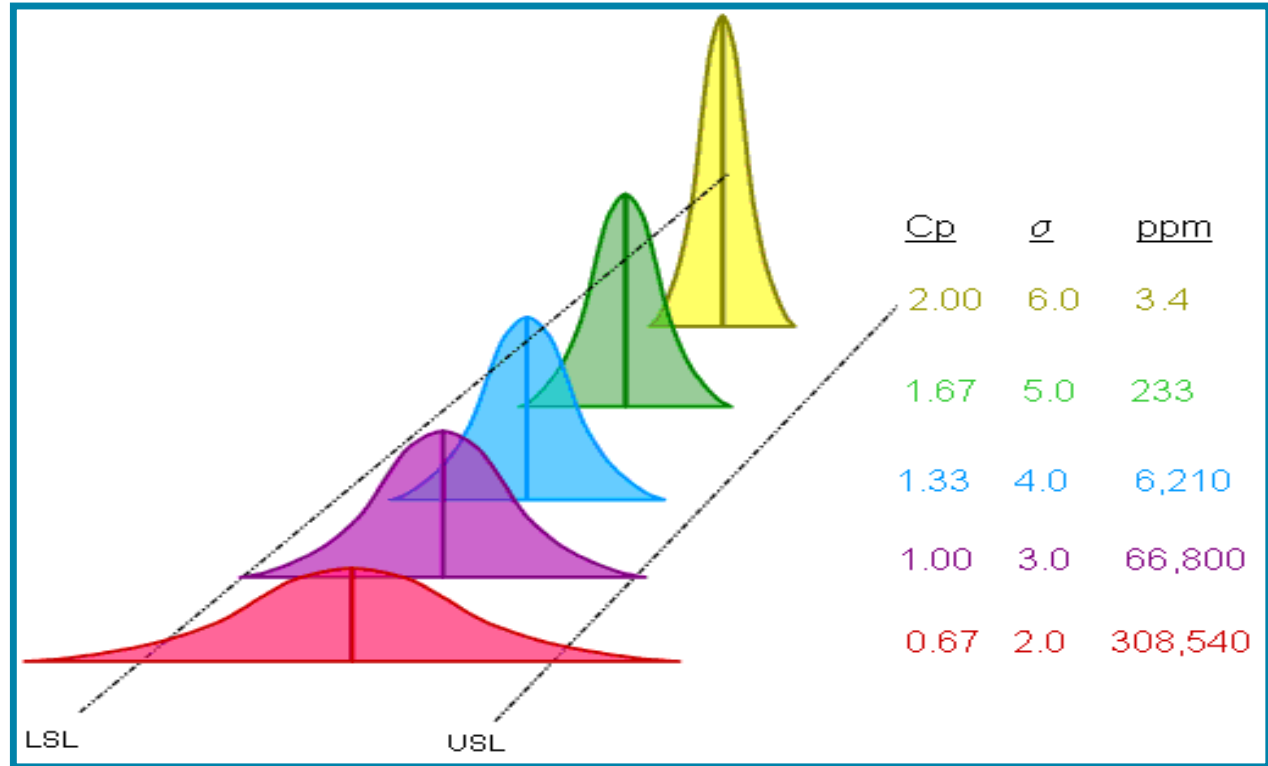


The diagram may look tricky to read, but in simple language: Consider that you run a pizza delivery business and you set a target of delivering pizza's within 25 minutes of receiving the order. If you achieve that 68% of the time, you are running at 1 Sigma. If you achieve it 99.9997% of the time then you are at 6 Sigma (or you are late on average only 3.4 times out of every one million orders).

Narrowing the Variation

Six sigma measures quality by measuring the *Variance*; it does not rely on the *Mean*.

It is argued that all too often businesses base their performance on a mean, or average-based measure, of the recent past. However, reality is that customers DON'T judge businesses on averages. They actually experience the variance in each and every transaction or purchase.



Examples of Sigma Levels

Example: If a passenger flew each day of their lives, how long could she/he fly without an airplane crash?

<u>Sigma Level</u>	<u>Time to Crash</u>
4σ	5 months
4.5σ	2 years
5σ	11 years
6σ	772 years

Healthcare in the US and Sigma Level

- ▶ NEJM estimates that 44% to 55% of patients do not get the care indicated by evidence

Sigma between 1.65 and 1.40

Lean Six Sigma

▼ Two Origins

- ▼ Six Sigma is a problem-solving method to drive dramatic improvements in dashboard metrics and to launch new products, services, and processes flawlessly.
- ▼ Lean is a set of methods to eliminate non-value added tasks and increase speed

ARTICLE IN PRESS

THE PRACTICE OF EMERGENCY MEDICINE/REVIEW ARTICLE

Lean Thinking in Emergency Departments: A Critical Review

Richard J. Holden, PhD

From the School of Medicine and Public Health, University of Wisconsin–Madison, Madison, WI, and the Division of Ergonomics, School of Technology and Health, Royal Institute of Technology, Stockholm, Sweden.

Emergency departments (EDs) face problems with crowding, delays, cost containment, and patient safety. To address these and other problems, EDs increasingly implement an approach called Lean thinking. This study critically reviewed 18 articles describing the implementation of Lean in 15 EDs in the United States, Australia, and Canada. An analytic framework based on human factors engineering and occupational research generated 6 core questions about the effects of Lean on ED work structures and processes, patient care, and employees, as well as the factors on which Lean's success is contingent. The review revealed numerous ED process changes, often involving separate patient streams, accompanied by structural changes such as new technologies, communication systems, staffing changes, and the reorganization of physical space. Patient care usually improved after implementation of Lean, with many EDs reporting decreases in length of stay, waiting times, and proportion of patients leaving the ED without being seen. Few null or negative patient care effects were reported, and studies typically did not report patient quality or safety outcomes beyond patient satisfaction. The effects of Lean on employees were rarely discussed or measured systematically, but there were some indications of positive effects on employees and organizational culture. Success factors included employee involvement, management support, and preparedness for change. Despite some methodological, practical, and theoretic concerns, Lean appears to offer significant improvement opportunities. Many questions remain about Lean's effects on patient health and employees and how Lean can be best implemented in health care. [Ann Emerg Med. 2010;xx:xxx.]

Strategies to Improve Quality

- ▼ Pro-Active
 - ▼ Leader/Physician Rounding
 - ▼ Dashboard/Action Plan
 - ▼ Discharge Follow-Up Phone Calls
- ▼ PI/Six Sigma/Lean
- ▼ **Retrospective**
 - ▼ **Systems Metrics**
 - ▼ **Quality Assurance**
 - ▼ **Clinical Compliance**

Quality – Individual Staff

- ▼ *Ongoing monitoring of physician competencies via case/peer review, patient/ ED staff/medical staff surveys, direct observation, complaints*
- ▼ *Ongoing monitoring of departmental competencies via dashboard, action plan, verification of compliance*

Specific Peer Case Review

- ▼ First . . . 2 issues to decide:
 - ▼ Was standard of care met?
 - ▼ Was compliance (documentation) met?
- ▼ Score case and give feedback
- ▼ Track and Trend
- ▼ Focused Review
- ▼ Present case at ED dept meeting
- ▼ Refer to other committees prn

Annual Physician Evaluation

IE= Improvement Expected ME = Meets Expectations A scoring of "IE" requires an explanation in the comments section		
CEP PARTNER PERFORMANCE STANDARDS As required by Policy and evidenced by pooled information such as MARS, education logs, MAM claims, etc...	IE	ME
PATIENT SATISFACTION <ul style="list-style-type: none"> ■ Scores ■ Patient Complaints 	<input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
RISK MANAGEMENT: Number of claims if known, peer review, COBRA/EMTALA	<input type="checkbox"/>	<input checked="" type="checkbox"/>
PARTICIPATION AT LOCAL MEDICAL FACILITY/PARTNERSHIP: (Department meeting attendance, committee service, special contributions, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
PERSONAL PRACTICE Individual Practice Standards -	IE	ME
CLINICAL SKILLS: Medical knowledge and judgment, deep fund of knowledge and willingness to learn, thoughtful integration of medical data with excellent patient evaluation and management skills	<input type="checkbox"/>	<input checked="" type="checkbox"/>
CLINICAL PERFORMANCE: Appropriate Use of Resources, thoroughness of Documentation, quality of Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Summary

- Involve your team
- Evaluate the entire ED and individuals
- Be Pro-Active – Rounding
- Coach for Opportunities/Recognize positive behavior
- Be fair but tough
- A strong QI program protects not only patients, but also providers, ED staff and hospital



No one said it was going
to be easy . . .

Thank you.
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