

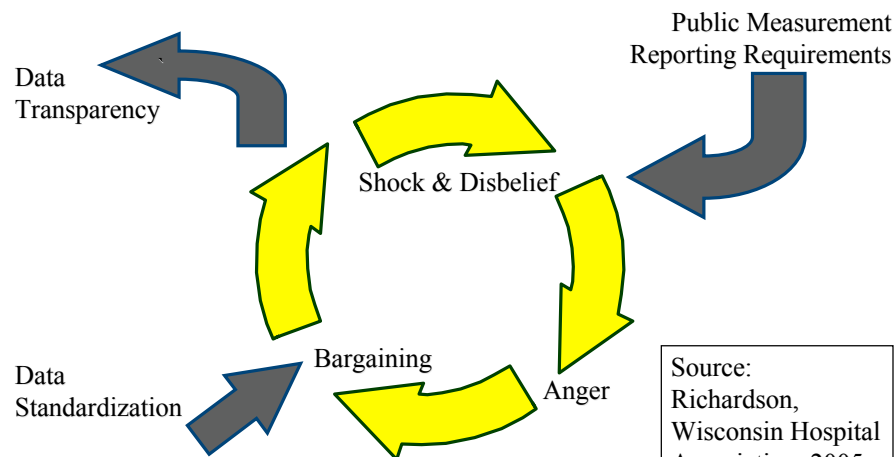


Rural Hospital Leadership & Quality Improvement



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Hospital Quality Leaders Work Through “Death & Dying” Cycle



“Quality Measurement, Pay for Performance and Rural Hospitals” by Ira Moscovice,
Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007
NRHA Annual Meeting, 5/17/07



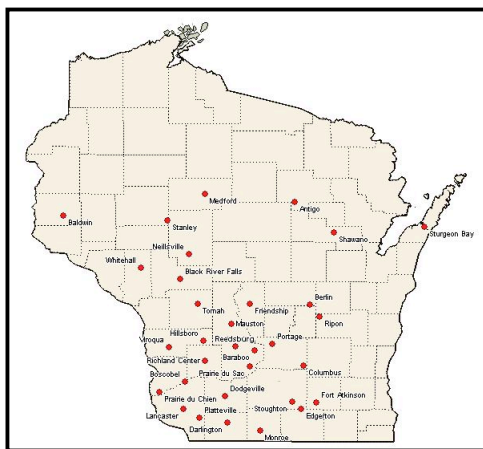
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Presentation Outline

- I. Brief Overview of RWHC
- II. Health System at Tipping Point
- III. Institute of Medicine: “Future Rural Health, Quality Through Collaboration”
- IV. Challenge from CMS Hospital Compare Data
- V. What Can I Do Now?
- VI. Pay 4 Performance in Wisconsin
- VII. National View: Opportunities & Challenges
- VIII. Q & A

RWHC - Who We Are?

- Founded in 1979, a non-profit cooperative owned & operated by 32 community hospitals; all well < 100 beds
- Aggregate budgets >\$0.5B; >2,000 hospital & nursing home beds).
- 26 are CAHs; 19 are traditional independent, 5 are with management companies & 8 are system affiliated.





RWHC Vision & Mission

RWHC Vision (Future we want):

Rural Wisconsin communities will be the healthiest in America.

RWHC Mission (How we do it):

RWHC is a strong and innovative cooperative of diversified rural hospitals.

... is the “rural advocate of choice” for its Members.

... develops and manages a variety of products and services.

... assists Members to offer high quality, cost effective healthcare.

... assists Members to partner with others to make their communities healthier.

... generates additional revenue by services to non-Members.

... actively uses strategic alliances in pursuit of its Vision.

RWHC Strategic Plan Updated 5/4/07



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RWHC Quality Related Activities (Partial)

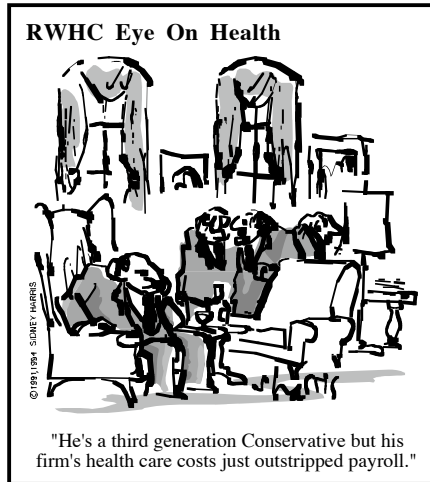
- Professional Roundtables--Most of the about 40 roundtables meet 4-6 times per year, typically for 2-4 hours per meeting. Several of the professional roundtables devote meeting time to the development and review of competencies for their positions, which serves both a functional purpose for their respective facilities and satisfies JCAHO requirements.
- RWHC Quality Indicators Program--JACHO accredited; 15 year track record of successful data collection and management, serving more than 100 facilities representing over twenty states.
- CAHPS Hospital Survey
- NCQA Credentials Verification Service & Peer Review Service
- Health Information Technology & EHR Development
- Advocacy/Education



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Health System at Tipping Point



- Safety – Tens of thousands die due to errors (IOM, '99)
- Effectiveness – 50/50 chance of getting appropriate care (McGlynn, '03)
- Uninsured – Over 40 million people (IOM, '03)
- Racial and ethnic disparities
- Workforce shortages and turnover
- Rapidly rising costs

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Unsustainable Utilization Drives Cost Inflation

- Health care spending per privately insured person increased 7.4% in 2005
- The trend for 2005 reflected increased growth in spending for hospital and physician care
- Hospital utilization trends accelerated, while price trends decelerated in 2005.
- Continues to outpace growth in the economy (5.9%) and workers earnings (3.8%)

"Tracking Health Care Costs: Continued Stability But At High Rates In 2005" Health Affairs, Web Exclusive, 10/3/06



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Factors Underlying System Failures

- Poorly organized delivery system
- Lack information technology infrastructure
- Inadequate workforce
- Toxic payment system

Slide From: “Quality Measurement, Pay for Performance and Rural Hospitals” by Ira Moscovice, Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007 NRHA Annual Meeting, 5/17/07



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Quality Reform Must Go “Upstream”

“Preventive and primary care quality deficiencies undermine outcomes for patients & contribute to cost.”

“Savings can be generated from more efficient use of expensive resources including more effective care in the community to control chronic disease and timely access to primary care.”

“Why Not the Best?” from the Commonwealth Fund
Commission on a High Performance Health System, 9/20/06

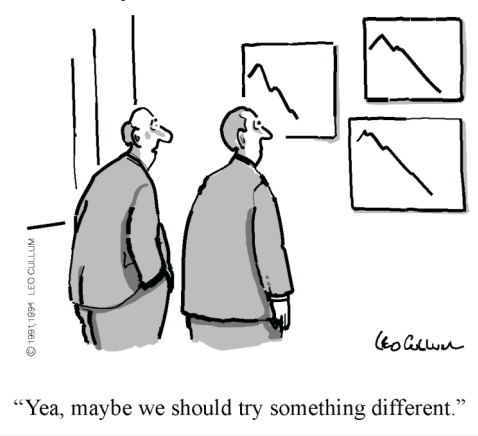


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The Institute of Medicine Rural Report on Quality

RWHC Eye On Health



The rural hospitals that survive will be the institutions that demonstrate they are able to provide good quality care:

- ♦ IOM Reports
- ♦ CMS Medicare Hospital Compare Database
- ♦ Pay for Performance/Value-Based Purchasing

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Chpt 1: The Committee's 5-Part Proposed Strategy

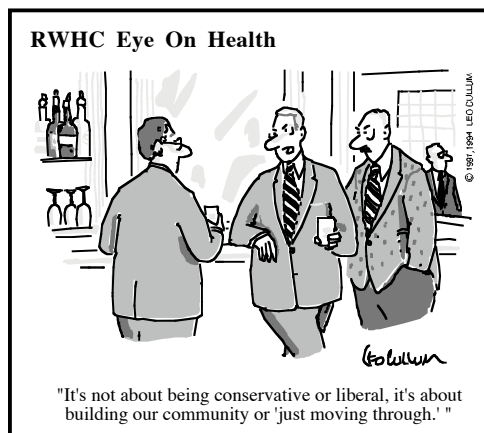
- Adopt an integrated approach to addressing personal and population health needs at the community-level.
- Establish a stronger quality improvement support structure to assist rural systems and professionals.
- Enhance human resource capacity of rural communities (professional and rural residents).
- Monitor and assure that rural health care systems are financially stable.
- Invest in building an information and communications technology (ICT) infrastructure.

Committee on the Future of Rural Health Care. *Quality through collaboration: the future of rural health care*. Washington, DC: National Academies Press; 2004.



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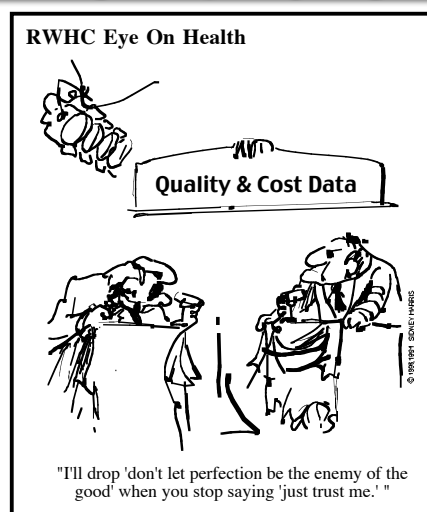
Chpt 2: Individual & Population Health



"Rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations."

Committee on the Future of Rural Health Care. *Quality through collaboration: the future of rural health care*. Washington, DC: National Academies Press; 2004.

Chpt 3: Quality Improvement Infrastructure

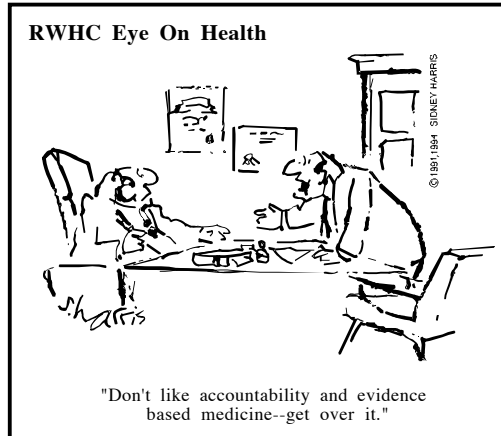


"A great deal of attention has been focused on enhancing quality improvement capabilities. Because of their small scale and low operating margins, rural providers have found it difficult to make such investments. Although many elements will be the same for rural and urban areas, some customization is needed for rural areas."

Committee on the Future of Rural Health Care. *Quality through collaboration: the future of rural health care*. Washington, DC: National Academies Press; 2004.



Chpt 5: Provide Adequate Financial Resources



"Communities must have adequate, appropriately financial resources. A great deal of experimentation is under way to better align payment incentives with the quality aims; rural communities should be part of these efforts. But rural health care systems have been financially fragile, and many still have small operating margins, making it difficult to participate."

Committee on the Future of Rural Health Care. *Quality through collaboration: the future of rural health care*. Washington, DC: National Academies Press; 2004.



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CAH Participation in Hospital Compare in '05

- 53% of CAHs participated as of 9/06.
- CAHs are more likely to participate if they are larger, accredited, system members, later converters and have private non-profit ownership.
- Volume is an issue: More than half of participating CAHs reported data for greater than 25 patients on 3 pneumonia measures
- Less than 4% of participating CAHs reported data for greater than 25 patients on all AMI measures

Source: University of Minnesota analysis of Hospital Compare Data for 2005

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Hospital Compare Results for Hospitals with Data for both 2004 and 2005 Discharges					
		CAHs (n=558)		Urban Hospitals (n=2,333)	
Condition	Measure	2004	2005	2004	2005
AMI	Aspirin at arrival	89.2	87.9	94.9	95.7
	Aspirin at discharge	84.5	85.7	94.7	95.9
	ACE inhibitor or ARB for LVSD	72.7	76.8	79.6	83.7
	Beta blocker at arrival	80.5	80.7	90.3	92.6
	Beta blocker at discharge	81.3	85.7	92.6	95.1
	Smoking cessation advice	50.5	64.3	86.3	92.4
	Thrombolytic w/in 30 minutes of arrival	27.8	32.4	38.2	38.2
	PCI at arrival	N/A	N/A	65.0	69.1

Hospital Compare Results for Hospitals with Data for both 2004 and 2005 Discharges					
		CAHs (n=558)		Urban Hospitals (n=2,333)	
Condition	Measure	2004	2005	2004	2005
Heart Failure	Assessment of LVF	65.1	69.7	88.8	91.9
	ACE inhibitor or ARB for LVSD	73.1	79.0	76.1	83.1
	Discharge instructions	45.7	52.6	51.5	58.7
	Smoking cessation advice	57.6	65.1	72.6	83.9

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Hospital Compare Results for Hospitals with Data for both 2004 and 2005 Discharges					
Condition	Measure	CAHs (n=558)		Urban Hospitals (n=2,333)	
		2004	2005	2004	2005
Pneumonia	Oxygenation assessment	98.4	99.2	98.9	99.5
	Pneumoccal vaccination	54.2	65.7	45.4	60.6
	Initial antibiotic(s) w/in 4 hours	82.3	84.5	69.2	73.9
	Blood culture prior to first antibiotic	82.5	82.9	82.1	83.1
	Smoking cessation advice	59.7	65.1	68.4	79.9
	Most appropriate initial antibiotic(s)	74.2	78.0	76.5	81.1

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Hospital Compare Results for Hospitals with Data for both 2004 and 2005 Discharges					
Condition	Measure	CAHs (n=558)		Urban Hospitals (n=2,333)	
		2004	2005	2004	2005
Surgical Infection Prevention	Preventative antibiotic(s) 1 hour before incision	63.4	73.2	76.3	82.2
	Preventative antibiotic(s) stopped within 24 hours after surgery	59.3	72.8	62.8	68.8

Slide from: “Quality Measurement, Pay for Performance and Rural Hospitals” by Ira Moscovice, Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007 NRHA Annual Meeting, 5/17/07



CMS Hospital Compare Data Summary

- CAHs as a group are performing:
 - ♦ As well or better than urban hospitals on half of the pneumonia measures and surgical infection prevention measures
 - ♦ Not as well as urban hospitals on all of the quality measures for AMI and CHF
- CAHs improved over time on all but 1 measure but the gap in performance compared to urban hospitals was not reduced for the majority of measures.

Slide from: “Quality Measurement, Pay for Performance and Rural Hospitals” by Ira Moscovice, Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007 NRHA Annual Meeting, 5/17/07



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CMS Hospital Compare Data Summary

- What are the reasons for the above results?
 - ♦ Availability of specialists and technology
 - ♦ Use of clinical and administrative guidelines/protocols
 - ♦ QI/Continuing education programs
 - ♦ Patient volume
 - ♦ Documentation issues
 - ♦ Systems issues (e.g. related to turf control)
- Develop quality measures for core rural hospital functions not considered in existing measurement sets
 - ♦ Emergency department (timeliness of care)
 - ♦ Transfer communication
 - ♦ Outpatient care

Slide from: “Quality Measurement, Pay for Performance and Rural Hospitals” by Ira Moscovice, Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007 NRHA Annual Meeting, 5/17/07



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From RWHC: What Can I Do Now? (1 of 2)

Data Collection & Feedback

- collect data on patient care processes and outcomes
- develop a reporting format that is easy to read
- report results continually to everyone
- change “incident” reporting to “opportunity to improve”

External Benchmarks

- improve JCAHO Core measure data: CHF, AMI & CAP
- recognize as important, implement and monitor the JCAHO National Patient Safety Goals
- change systems to comply with patient safety measures such as requiring site marking, identifiers before treatment, etc.
- develop Care Pathways for consistency of care

RWCH Hospitals' Quality Directors Survey, 8/05



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From RWHC: What Can I Do Now? (2 of 2)

- respond to insurers' measures for quality such as compliance with diabetes management
- implement bar code scanning for medication administration
- there are a lot of resources; “God Bless the internet!”

Team Work

- promote a non-punitive environment
- work towards a culture of teamwork
- develop small quality action teams
- charter a proactive medication management team
- utilize patient care council to problem solve clinical issues
- train/orient new personnel with strong preceptors
- develop stronger physician/nursing relationships

RWCH Hospitals' Quality Directors Survey, 8/05



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From WHA: What Can I Do Now? (1 of 2)

- Evaluate where your hospital is related to the “Death and Dying” cycle of change
- Identify impediments to improvement in your hospital
- Increase visibility and communication about quality issues
 - ♦ Increase focus on quality at Board meetings
 - ♦ Find opportunities for your Board and senior leadership to interact with physicians and staff about quality issues
- Participate in Pay for Performance
 - ♦ Purchaser pilots
 - ♦ Incorporate quality targets into senior leadership compensation (and staff)

“Leadership Keys to Improving Quality of Care” by Dana Richardson, Vice President,
Quality Initiatives, Wisconsin Hospital Association, 2005 Rural Health Conference



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From WHA: What Can I Do Now? (2 of 2)

- Use quality measures to assist decision making
 - ♦ Public reporting (CheckPoint, Hospital Compare)
 - ♦ Organizational scorecards/dashboards
- Participate in learning/sharing opportunities
 - ♦ State Hospital Association Initiatives
 - ♦ Rural tasks in QIO 8th Scope of Work
 - ♦ 100K Lives Campaign
 - ♦ NRHA Quality Initiative
- Develop a comprehensive plan to build a systems approach and create a culture of excellence

“Leadership Keys to Improving Quality of Care” by Dana Richardson, Vice President,
Quality Initiatives, Wisconsin Hospital Association, 2005 Rural Health Conference



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Pay 4 Performance: Incentives to do “Right Thing”

RWHC Eye On Health



“Same problem. We were doing good until our patients couldn't afford us any longer.”

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

- Financial incentives by payer to reward/improve quality of care as well as to control costs by reducing errors & inappropriate utilization.
- 80+ health plans expected to have P4P programs in 2006, covering some 60 million members.
- Medicare calls it “Value Based Purchasing.”



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Examples of Pay 4 Performance Focus

- Utilization/cost management (e.g., average number of emergency department visits per patient per year).
- Clinical quality/effectiveness (e.g., the percentage of patients with asthma on controller medications).
- Patient satisfaction (e.g., the percentage of patients who would recommend the physician to a family member or friend).
- Administrative (e.g., the practice's level of information technology).
- Patient safety (e.g., the percentage of patients questioned about allergic drug reactions).

“The Basics of Pay for Performance,” Family Practice
Management 11(3):45-50, 2004.



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The Alliance’s P4P Measures (Hospital Inpatient)

Varying stages of implementation

- Mortality (APR DRGs)
- Potentially Preventable Aftercare:
 - ♦ Readmissions
 - ♦ Emergency Care
 - ♦ Urgent Care
- Leapfrog ICU Standard
- Leapfrog CPOE Standard
- 3rd & 4th Degree Lacerations (Joint Commission)
- Primary C-Sections (AHRQ)

Dean Health Plan P4P ‘07 & *Proposed* ‘08

- Currently, provider eligible to earn, an additional six tenths of a percent (0.6%), based on claims payment during prior quarter.
- RWHC has 3 reps, Hospital Quality Metrics Advisory Committee.

Organization	Metric	+ \$% in ‘07 & ‘08
Checkpoint	Report AMI, CHF, Pneumonia clinical measures.	+ .2% & ?
Checkpoint	Report surg.site marking, procedure verification, eliminate dangerous med abbrev., remove concentrated electrolytes, <i>med. reconciliation.</i>	+ .2% & ?
<i>Checkpoint</i>	<i>Achieve pneumonia care perform goal</i>	?
Leapfrog	Receive a Leapfrog score of 1/4.	+ .2% & ?



Is P4P Good Investment for Improving Care?

- Hospitals participating in a voluntary quality-improvement program for heart attack patients performed as well on quality measures for heart attack care as participants in a federal pay-for-performance demonstration.
- Both groups of hospitals saw improvement over the three-year period on scores for care processes rewarded by the Centers for Medicare & Medicaid Services demonstration. However, there was no significant difference between the groups scores.

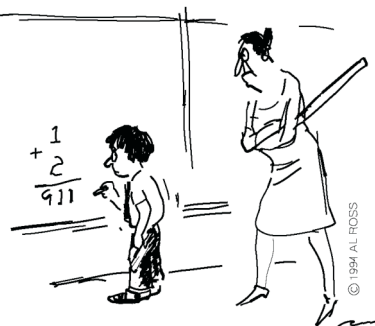
"Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction," Journal of the American Medical Association, 6/6/07



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National View: Opportunities & Challenges (1 of 3)

RWHC Eye On Health



One solution to a "small numbers" problem.

- In a more price sensitive market, rural providers need to work more collaboratively, harder and smarter to make up for fewer economies of scale and higher stand-by costs.
- To date, the measures used to evaluate providers have often not addressed statistical issues of "small numbers," mix of services and characteristics of population served.

"Small numbers are a big deal" by Tim Size,
Modern Healthcare, 5/14/07



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National View: Opportunities & Challenges (2 of 3)

- All providers must be given the opportunity to demonstrate that their quality of care and cost effectiveness is driven by evidence-based medicine and cost effective leadership.
- Some providers say: “they & their data should just be left alone.”
- Some payers/experts say their work is complicated enough without the challenge of “small numbers.”
- For whatever reason, No Data = “Backwater Status.”
- Dysfunctional cacophony of measurement voices.
- Too much waste addressing multiple, similar demands.

“Small numbers are a big deal” by Tim Size,
Modern Healthcare, 5/14/07



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National View: Opportunities & Challenges (3 of 3)

- A coherent strategy requires that we be “at the table.”
- Confounding factors need to be considered-sickest heart attack patients may stay at hospital close to family while the healthiest are transferred to an urban hospital.
- “Small counts” raise concerns about reliability (the repeatability of the measure) and validity (whether the intended target population is being measured).
- We can expand sample size by aggregating data over time or aggregating data across metrics.
- Beyond statistical approaches, peer review mechanisms should be implemented to assure appropriate care.

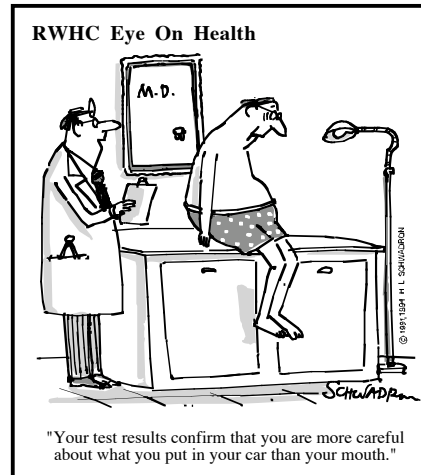
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Modern Healthcare, 5/14/07



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Rural Can Also Lead in Population Health



"The healthcare system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal healthcare with broader community-wide initiatives that target the entire population."

Fostering Rapid Advances In Healthcare: Learning From System Demonstrations,
The Institute of Medicine of the National Academies of Science, 2002.



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Medical Sector Not Only Driver of Health Costs

- Access to Health Care (est 10%)
- Health Behaviors (est 40%) e.g. smoking, physical inactivity.
- Socioeconomic factors (est 40%) e.g. education, poverty, divorce rates.
- Physical environment (est 10%)

2005 Wisconsin County Health Rankings, University of Wisconsin
Population Health Institute



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IOM Quality Aim	Traditional Personal Health Care View	Rural IOM Population Health Community View
Safety	Reduce medication errors.	Reduce auto accidents.
Effectiveness	Use best practices to care for diabetic patients.	Public school policies reduce risk obesity/diabetes.
Individual-Centered	Improve provider & patient communication.	Regional networks respect community preferences.
Timeliness	Appointments available within reasonable limits.	Epidemics and other threats to community as whole identified earlier than later.
Efficiency	Investing in electronic health records as a means to more efficient care.	Public reporting of population-based measures of health status.
Equity	Treat all patients with equal respect.	Public policies that encourage appropriate distribution of providers.

Critical Link of Population & Economic Health

“Businesses will move to where healthcare coverage is less expensive, or they will cut back and even terminate coverage for their employees. Either way, it's the residents of your towns and cities that lose out.”

Thomas Donohue President & CEO,
U.S. Chamber of Commerce

“If we can change lifestyles, it will have more impact on cutting costs than anything else we can do.”

Larry Rambo, CEO,
Humana Wisconsin and Michigan



The Hospital's Risk of Not Changing

"Healthcare 'markets' are now being redefined; shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives."

"This developing redefinition of healthcare needs to be reflected in rural provider strategic planning. It is a great opportunity for rural health."

Original Source: "Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation," Tim Size, David Kindig & Clint MacKinney

Slide from: "Quality Measurement, Pay for Performance and Rural Hospitals" by Ira Moscovice, Ph.D., Professor and Director, Upper Midwest Rural Health Research Center, at 2007 NRHA Annual Meeting, 5/17/07



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