

**Implementing ALL the
consensus standards:
the journey so far**

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Outline

- What we did
- Getting started
- Going public
- Impact
- Evaluation

What we did

- Published our **red-green** performance

[www.NortonHealthcare.com 3/31/2005]

- On more than 200 (now 340) nationally recognized indicators of hospital clinical quality
- Voluntarily



Our report includes all the consensus standards for:

■ NQF

- hospital care
- cardiac surgery
- nursing-sensitive care
- safe practices
- *coming soon (now here):* ambulatory care

Our report also includes:

■ AHRQ

- patient safety indicators
- inpatient quality indicators

■ JCAHO

- national patient safety goals
- pediatric ORYX

Cardiac surgery example

brief description	desired
% heart b internal m	crds06
% heart b preoperat	Number of heart bypass procedures per 100, that use the internal mammary artery as a graft. This is a common open heart surgery where surgeons bypass blockages of the coronary arteries using the internal mammary artery as a graft.
% heart b preop. and	The use of an internal mammary artery increases the likelihood of a good long-term outcome for the patient.
% heart b discontinu	<u>Technical</u>
% heart b more than	Includes inpatients discharged with any procedure of coronary artery bypass graft (CABG). Excludes patients less than 20 years of age; excludes patients discharged with any additional cardiac surgical procedure; excludes patients with any previous CABG, valve, or other cardiac surgical procedure. (NQF HC 11 / NQF cardiac 6 / STS)

Evaluating the numbers

If numeric and have U.S. comparison, compute 99% confidence interval:

- “Better than U.S. average”
- “Near U.S. average” [within C.I.]
- “Worse than U.S. average”

Safe practices are a self-assessment.

safe practice

Implement a standardized protocol to prevent the mislabeling of radiographs. (NQF Safe Practice 13)



Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures. (NQF Safe Practice 14)



Evaluate each patient undergoing elective surgery for risk of an acute ischemic cardiac event during surgery, and provide prophylactic treatment of high-risk patients with beta blockers. (NQF Safe Practice 15)



Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventive methods should be implemented consequent to the evaluation. (NQF Safe Practice 16)



Upon admission, and regularly thereafter, evaluate each patient for the risk of aspiration. (NQF Safe Practice 19)



Adhere to effective methods of preventing central venous catheter-associated blood stream infections. (NQF Safe Practice 20)



Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventive methods should be implemented consequent to the evaluation.

(NQF Safe Practice 16)

In progress. Our hospitals use a rating scale to evaluate the risk of pressure ulcers on admission. More intense assessment of patients identified as at-risk is performed at intervals. Plan to convene a team to develop a more systematic approach after the evaluation.



Website: Questions & Answers

- What is in this Quality Report?
- How were these indicators and safe practices selected?
- Does this quality report display data about individual physicians?
- Is this information available for hospitals that are not part of Norton Healthcare?
- Why is Norton Healthcare publishing its quality data?
- What does "risk-adjusted" mean?
- If a hospital's performance is red, does that mean it provides bad care?
- How often will the data in this report be updated?

Website: Technical notes

- How did we decide when to color-code performance on a numeric indicator red or green?
- Why is Hospital A “average,” and Hospital B “better than average,” when Hospital B has a worse percentage than Hospital A?
- How does risk adjustment work?
- Where did these indicators come from?
- Where are the data sources for these numbers?
- What are some of the known limitations of our report on these indicators and safe practices?

Getting started

- Deciding to go public

Why we did it

- “(He’s) right! Psychotic, but absolutely right...Now we could do it with conventional weapons, but that could take years and cost thousands of lives...I think that this situation absolutely requires a really futile and stupid gesture be done on somebody’s part...We’re just the guys to do it.
- Eric Stratton and John Blutarsky
AKA, Otter and Bluto
Animal House, 1978

What we hope we don't have to say to our Board

- "...you can't spend your whole life worrying about your mistakes. You *&%\$*ed up. You trusted us. Hey, make the best of it...my suggestion to you is to start drinking heavily.
- Eric Stratton and John Blutarisky
AKA, Otter and Bluto
Animal House, 1978

Question

**If you know your death rate for
some procedure is 2.6%,
should the public know that, too?**

To improve, hospitals must

1. find out what their results are.
2. analyze their results,
to find their strong and weak points.
3. compare their results with those of other hospitals
[How?? If it's all secret.]
4. welcome publicity not only for their successes,
but for their errors...

Such opinions will not be eccentric a few years hence.

Dr. Ernest A. Codman

1917

Quote from: **The Role of Clinical Data and Risk Adjustment in Public Reporting of Hospital Performance.**

Massachusetts Health Data Consortium. December 10, 2003.

RS Johannes, MS, MD, Vice President for Medical Affairs, Data & Clinical Information – Cardinal Health.

http://www.mahealthdata.org/forums/data/2003/DMUF_20031210_Johannes.pdf

Why we did it

- Accountability as a public asset
 - Clinical care is, in fact, our “widget”
 - We talk about our financials with bond raters, the press, etc.; why not our clinical performance?
- Proactively influence the the public reporting arena
 - Clinical over purely financial
 - Transparent over proprietary
 - Evidence based over arbitrary
- Get the organization moving in a direction that is inherently inevitable
- Improve our care; “We’ll manage what we measure and report”

Why do it when the indicators are less than perfect?

- Diabetes Mellitus (circa 1970)
 - Fasting Blood Sugar
 - Glycosuria
- Hyperlipidemia (circa 1980)
 - Total Cholesterol < 240
- Systolic Hypertension (circa 1980, ?now)
 - Who cares if the diastolic is OK ?
- No one manages to these standards today, but management to these indicators produced demonstrable outcome improvement in their day
- Using the indicators made the indicators better

Getting started

- **Obtaining and keeping board and leadership commitment**
 - Gave board quality committee the lead
 - Moved quickly, before resistance could organize
 - Created sense of inevitability
 - “A lot of this is already out there.”
 - Committed ourselves with local media months in advance.

Getting started

- **Choosing what to publish**
 - “Let’s just use AHRQ and NQF.”
 - Short-circuit the definition battle by
 - Choosing entire lists instead of deciding indicator by indicator
 - **Not** being the indicator owner
 - **not** redefining the measure
 - **not** applying local reinterpretations of exclusion criteria

Going public

- Infrastructure needed
 - To collect, analyze, and display the data
 - To analyze and improve performance
 - Our total FTE count for this work is still very small (10-12)
- Tips about the analysis and display of the indicators
 - “The number is what the number is.”
 - The importance of flagging **good** and **bad** performance

Impact

of implementing the consensus standards

- We are still in business.
- Better data; less time arguing about the measure and more time improving performance.
 - Unused data never become valid.
 - Even a lousy indicator can drive improvement.
- Limited public reaction
- Mostly favorable physician response
- Strong desire to be “within normal limits”

Perhaps the **most noteworthy recent development** is the **surprising announcement** by Norton Healthcare, the five-hospital system based in Louisville, Ky., that it will soon begin to publish **the widest array of quality data of any U.S. healthcare provider.** ... Indicators won't be dropped if the hospital's performance is lagging behind ...

Quality without a pointed gun. *Modern Healthcare*, Feb. 21, 2005. p. 22.

For decades, recalcitrant hospital operators have resisted the idea of a public report card of their services, a kind of yardstick to compare their performance to local and national data of the same kind. Such information would be impossible to assess fairly, they claimed. What's more, it would confuse patients, they asserted. And it might be, well, negative.

Yes, it might be. Louisville's Norton Healthcare has defied traditional logic with its nationally acclaimed reporting system, which airs the hospitals' linen – both clean and dirty – for all to see. **It is an astonishing document....**

Courier-Journal, editorial, April 2, 2005.

Evaluation

- **What we've learned about the measures**
 - Few existing tools to automate or streamline any of this.
 - Comparative data are hard to find
 - Wide variation in clarity of definition, sensitivity and specificity, and ease of use
 - Too many local decisions about details of collection, analysis, and display [too much potential variation]

Evaluation

- **Implementing the consensus standards**
 - Turned up the heat on improving our performance
 - Increased alignment about what to tackle
 - IT agenda better aligned
 - Strategic capital better aligned
 - Physician workforce better aligned
 - Created new feedback about the ultimate effectiveness of attempts to improve
 - Had few downsides
[Come on in. The water's fine.]