Quality Leadership Summit
Keynote Address

Brian Haapala, MSHA, FACHE
Managing Director, Stroudwater Associates

David Palm, PhD
Flex Coordinator, Nebraska Office of Rural Health

Ed Gamache
CEO, Harbor Beach Community Hospital,
President, Michigan Critical Access Hospital Quality Network (MICAH)

2011 National Conference of State Flex Programs
July 12, 2011
Neanderthal
- Lived from 400,000 to ~30,000 years ago
- Homo sapiens lived from 250,000 years ago
- Apex predator; bigger and stronger than homo sapiens; similarly-sized brain

Darwin – Natural Selection
- “Better adapted for immediate, local environment”
Public Views on Differences in Quality

- Differences in the quality of care among local hospitals where you live?

<table>
<thead>
<tr>
<th>Survey</th>
<th>Big differences</th>
<th>Small differences</th>
<th>No differences</th>
<th>Don't know/refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFF / AHRQ 1996</td>
<td>38%</td>
<td>32%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>KFF / AHRQ 2000*</td>
<td>47%</td>
<td>31%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>KFF 2008</td>
<td>41%</td>
<td>32%</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>RWJ / HSPH 2011</td>
<td>35%</td>
<td>36%</td>
<td>23%</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Based on half sample

Which do you chose: the hospital you and your family have used or another hospital that is rated higher?

<table>
<thead>
<tr>
<th>Study</th>
<th>Hospital you and your family have used for years</th>
<th>Hospital rated much higher in quality by experts</th>
<th>Don't know / refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>KFF / AHRQ 1996</td>
<td>72%</td>
<td>25%</td>
<td>3%</td>
</tr>
<tr>
<td>KFF / AHRQ 2000*</td>
<td>62%</td>
<td>32%</td>
<td>6%</td>
</tr>
<tr>
<td>KFF / AHRQ / HSPH 2004*</td>
<td>61%</td>
<td>33%</td>
<td>6%</td>
</tr>
<tr>
<td>KFF 2008</td>
<td>59%</td>
<td>35%</td>
<td>6%</td>
</tr>
<tr>
<td>RWJ / HSPH 2011</td>
<td>57%</td>
<td>38%</td>
<td>5%</td>
</tr>
</tbody>
</table>

* Based on half sample

Rural (blue) is Both Older and Poorer

Percent of Population Age 65+, 2009

- Not in MSA: 19.8%
- In MSA: 12.6%

Percent of Population in Poverty, * 2009

- Not in MSA: 16.6%
- In MSA: 13.9%


* Poverty defined as <100% FPL.
Note: MSA is metropolitan statistical area.
Rural (blue) has More Chronic Disease

Age-adjusted Percentage of Individuals with Select Chronic Conditions, 2009

- **Hypertension**: 27.3% (Not in MSA), 24.7% (Small MSA), 22.4% (Large MSA)
- **Emphysema**: 2.5% (Not in MSA), 2.3% (Small MSA), 1.8% (Large MSA)
- **Chronic Bronchitis**: 5.1% (Not in MSA), 4.7% (Small MSA), 3.7% (Large MSA)
- **Cancer**: 9.5% (Not in MSA), 8.3% (Small MSA), 7.2% (Large MSA)
- **Diabetes**: 8.9% (Not in MSA), 9.6% (Small MSA), 8.2% (Large MSA)


Note: MSA is metropolitan statistical area. Large MSAs have a population of 1 million or more; small MSAs have a population of less than 1 million.
Pop Quiz

What do older, poorer, and sicker people need most from healthcare?
Rural Already Providing More Outpatient Care

Outpatient as a Percent of Total Gross Revenue, Urban vs. Rural Hospitals, 1990 - 2009

Complex Processes, Involving Many Handoffs

Source: American Hospital Association.
In a Highly Regulated Environment

With Increasingly Limited Resources

44 state shortfalls, totaling $112 Billion

http://www.cbpp.org/slideshows/?fa=stateFiscalCrisis
## Better Quality to Save Costs

<table>
<thead>
<tr>
<th>ACA Provision</th>
<th>Ten-Year Cost Savings</th>
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</thead>
<tbody>
<tr>
<td>Reduce the number of hospital readmissions</td>
<td>$8.2 billion</td>
</tr>
<tr>
<td>Reduce hospital acquired conditions</td>
<td>$3.2 billion</td>
</tr>
<tr>
<td>Bundle payments for ESRD</td>
<td>$1.7 billion</td>
</tr>
<tr>
<td>Improve physician quality reporting</td>
<td>$1.9 billion</td>
</tr>
</tbody>
</table>

2 Centers for Medicare and Medicaid Services, 2010.

Rural Opportunity to Lead

- Improve quality
  - Points of care
  - Triple aim
  - Patient-centered

- Reduce costs
  - Prevention/early intervention
  - Primary care
  - Accountable Care
Lessons Learned from the Quality Leadership Summit: Implications for the FLex Program?

Dave Palm
Nebraska Office of Rural Health

National Conference of State Flex Programs
Portland, Maine

July 12, 2011
What were some of the key lessons learned?

What are some of the implications for the Flex Program?

How can the Flex Program move the quality leadership agenda forward?
Lessons Learned from the Quality Leadership Summit

• Adopt a system-based quality improvement (QI) framework
• Build leadership throughout the organization
• Measure results
• Continually focus on patients, physicians, and other customers
• Continually refine processes to improve performance
• Recommended using the Baldridge Model
  ▪ Accepted as a standard of excellence for health care performance
  ▪ Applies to both large and small organizations
  ▪ Provides a comprehensive blueprint for improving quality and performance
Baldrige Performance Excellence Framework

1. Leadership
2. Strategic Planning
3. Focus on Patient, Other Customers, and Markets
4. Measurement, Analysis, and Knowledge Management
5. Workforce Focus
6. Process Management
7. Results
Build Leadership Throughout the Organization

- Senior leaders must act as change agents

- Leaders create and promote the culture of an organization
  - Reward employees for the “right” behavior
  - Eliminate the “Culture of Blame”

- Leaders must understand the complexity of the system
Build Leadership

- Encourage open two-way communication
- Develop leaders throughout the organization
- Use Boards as part of the change process
  - Is quality an important item on the agenda?
Measure Results

- Widely communicate the results to staff, the Board, physicians, and the public

- Select indicators that are sensitive to rapid changes on unexpected events

- Use holistic measures that reflect the performance of the organization

- Initiate action when problems occur
**Mean Incidence Rates - Outcomes**

- **T-Test for difference between Non-CAH vs. CAH**

<table>
<thead>
<tr>
<th>Event Rate/1000 patient days</th>
<th>Non-CAH (47-689 beds, n=13)</th>
<th>CAH (12-25 beds, n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Falls</td>
<td>4.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Injurious Falls</td>
<td>0.9</td>
<td>0.1</td>
</tr>
</tbody>
</table>

*(Brown, 2010)*

**p=.004**

**p=.017**

*(T-Test for difference between Non-CAH vs. CAH)*
What do you do with your data?

- **Non-CAH (47-689 beds, n=14)**
  - Report Inj Falls Externally: 71%
  - Analyze and Track Outcomes over Time: 100%
  - Collect, Analyze Data, Modify P/P Based on Data, and RCAs: 64%
  - Benchmark Externally*: 69%

- **CAH (12-25 beds, n=56)**
  - Report Inj Falls Externally: 32%
  - Analyze and Track Outcomes over Time: 87%
  - Collect, Analyze Data, Modify P/P Based on Data, and RCAs: 29%
  - Benchmark Externally*: 28%

*p = .017, *p = .029, *p = .015

*Chi-Square Test With Continuity Correction
Focus on Patients and Customers

• Continuously assess patient satisfaction (HCAHPS)
• Seek input from customers, including physicians
• Obtain feedback from the community and assess community needs (ACA requirement)
Continuous process improvement is essential for breakthrough performance.

Several tools and models can be used to refine processes:
- Balanced Scorecard
- LEAN Management
- TeamSTEPPS
The Balanced Scorecard

- Links the hospital’s strategic initiatives together using a strategy map

- Measures progress in four quadrants
  - Workforce development
  - Internal processes
  - Customer satisfaction
  - Financial

- Should contain 24 or fewer measures with defined targets
LEAN Thinking

- LEAN is an approach that enables the true performance potential of a process ... to be realized.

- A LEAN organization continually improves patient safety, patient satisfaction, treatment outcomes, and employee development through the elimination of waste and errors and improvement in patient flow.

- It also involves employee engagement in solving problems and eliminating waste.
A LEAN Hospital

Goals: Safety, Quality, Time, Cost, Morale

Flow
- Prevent delays
- Value Stream focus
- Pull systems
- Right care, right place, right time

(Level Loading)

Developing People

Standardized Work

Quality
- Identify root causes
- Prevent errors at the source
- Involve employees
- Avoid blame

(Continuous Improvement)

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>TOOLS and STRATEGIES</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistency in Team Membership</td>
<td>Brief</td>
<td>Shared Mental Model</td>
</tr>
<tr>
<td>Lack of Time</td>
<td>Huddle</td>
<td>Adaptability</td>
</tr>
<tr>
<td>Lack of Information Sharing</td>
<td>Debrief</td>
<td>Team Orientation</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>STEP</td>
<td>Mutual Trust</td>
</tr>
<tr>
<td>Defensiveness</td>
<td>Cross Monitoring</td>
<td>Team Performance</td>
</tr>
<tr>
<td>Conventional Thinking</td>
<td>Feedback</td>
<td>Patient Safety!!</td>
</tr>
<tr>
<td>Complacency</td>
<td>Advocacy and Assertion</td>
<td></td>
</tr>
<tr>
<td>Varying Communication Styles</td>
<td>Two-Challenge Rule</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>CUS</td>
<td></td>
</tr>
<tr>
<td>Lack of Coordination and Follow-Up with Co-Workers</td>
<td>DESC Script</td>
<td></td>
</tr>
<tr>
<td>Distractions</td>
<td>Collaboration</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>SBAR</td>
<td></td>
</tr>
<tr>
<td>Workload</td>
<td>Call-Out</td>
<td></td>
</tr>
<tr>
<td>Misinterpretation of Cues</td>
<td>Check-Back</td>
<td></td>
</tr>
<tr>
<td>Lack of Role Clarity</td>
<td>Handoff</td>
<td></td>
</tr>
</tbody>
</table>
Most State Flex Programs are already working on all or most components of the Baldrige Model
- State and regional QI initiatives
- Leadership development efforts
- Strategic planning
- Patient satisfaction (HCAHPS)
- Workforce satisfaction
- Many new measures (Balanced Scorecard, LEAN, Hospital Compare, HSPSC)
Implications (continued)

- Flex Programs are using new tools, methods, and approaches
  - Balanced Scorecard
  - LEAN
  - TeamSTEPPS
  - Quality studies
    - Root cause analysis
    - Hospital Compare
    - Patient and employee satisfaction

- New opportunities for community assessments
Major Challenge
Overcoming the Spread

- How can we condense the time it takes the early and late majority to move through the change process?
- What about the laggards?
Knowledge Capture and Dissemination

Bell-Shaped Curve

- Laggards (~16%)
- Late Majority (~34%)
- Early Majority (~34%)
- Early Adopters (~16%)
How can the Flex Program Move the Quality Leadership Agenda Forward?

- Refocus on the components of the Baldrige Model

- Apply and enhance the tools that have been used successfully in some states (e.g., LEAN)

- Encourage all hospitals to participate in the Medicare Beneficiary Quality Improvement Project (MBQIP)

- Overcome the spread by disseminating “best practices” more quickly and creating new cultures that are more conducive to change
Conclusion

- The health care system is extremely dynamic and will continue to change rapidly.

- CAHs should use the Baldrige model to assure a comprehensive approach to quality improvement.

- The Flex Program has the tools to assist hospitals in becoming high performers, but greater sharing of best practices is still needed.
National Conference of State Flex Programs

Edward Gamache
CEO, Harbor Beach Community Hospital
President, Michigan Critical Access Hospital Quality Network (MICAH)
Lack of Perceived Value

“The care in the Thumb is scary!”
Former CEO-Tertiary Hospital near Harbor Beach

“We are concerned about quality!”
MI BCBS representative upon hearing Deckerville Community Hospital was selected as a procedure site by a neurosurgeon in April 2010

“I get no respect!”
Roger Dangerfield

“Oh please!”
Barb Cote, MI Quality Leader
Value = \( f(\text{Price, Quality, Satisfaction, Safety, Availability, Confidentiality}) \)
Value Based Purchasing – We Are Already There!
Cost Effectiveness

- CAHs represent 25% of Community Hospitals
- 60% of Rural Hospitals
- Less than 4% of CMS Hospital Costs
National Healthcare System Changes

- Accountability Care Organizations
- National Laboratory Information Exchange
- Partnership for Patients
- National Strategy for QI in Healthcare
- Dual Eligible Medicare Beneficiary HMOs
- IHI Triple Aim Regional Programs
- EHR/HIT Implementation
"Eliminate the Critical Access Hospital, Medicare-Dependent Hospital, and Sole Community Hospital Programs in Medicare"

"CAHs, MDHs, and SCHs are paid about 25 percent more, on average, for inpatient and outpatient services"

"Might force some of those hospitals to convert to outpatient facilities or even to close. To the extent that occurred, patients who reside in those areas might have difficulty getting access to care."
MICAH Medicare Inpatient Payment Per Stay Last Two Years of Life

Ratio of Cost to National Average

- Hackley Lakeshore Hospital
- Caro Community Hospital
- Spectrum Health Reed City
- Scheurer Hospital
- Allegan General Hospital
- Bell Hospital
- Charlevoix Area Hospital
- McKenzie Memorial Hospital
- Borgess-Henry Ford
- Eaton Rapids Medical Center
- Munising Memorial Hospital
- Schoolcraft Memorial Hospital
- Iron County Memorial Hospital
- Keweenaw Memorial Hospital
- Harbor Beach Medical Center
- Ionia County Memorial Hospital
- Hills and Dales General Hospital
- Straits Memorial Hospital
- Marlette Community Hospital
- Helen Newberry Loy Hospital

Source: Dartmouth Atlas Online
http://www.dartmouthatlas.org/
Traditional Support Threads May Deteriorate

- 45 State Flex Programs
- 90 US Senators
- Powerful Lobby
- National Debt may create “Desperate People”
- “Desperate People do Desperate Things”
Quality Summit Sharing System Thinking
System Map of: “Any System”

Input
- Environment
- Equipment

Processes
(The work we do)

Outputs
(products and services)

Customers
(internal and external)

Measurement and Feedback (How will we know?)
- Output Feedback
- Process Feedback
- Customer Feedback

Statement of Purpose – Most Important Aspect of System Drawing!

Aim and Purpose of the System
System Map of: US National Healthcare System

**Input**
- Environment
- Equipment
- Guidelines & Models
- People

**Processes** (The work we do)
- Community Health
- Education
- Provider Care Systems
- Hospital
- Physician
- LTC
- Pharmacy
- Social Services etc.
- Alternative Medicine
- Research & Education
- Public Information
- Patient Medical Information
- Technology Use
- Payment Processes
- Medicare/Medicaid
- Private Insurance

**Outputs** (products and services)
- Population Health
- Cost Effective Healthcare
- Benchmarking
- With other nations
- Reduction in Injury
- Reduced Mortality
- Educated Population
- Access for everyone
- For everything
- Cure of Disease
- Crisis Care

**Customers** (internal and external)
- Patients
- Communities
- Providers
- State & Federal Governments
- Business
- Wall Street
- Insurers
- Political System of Leaders
- Education System

High Performance Healthcare System.
System Map of: US National Healthcare System

Input (The work we do)
- Environment
- Equipment
- Guidelines & Models
- People

Outputs (products and services)
- Population Health
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  - Benchmarking With other nations
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- Political System of Leaders
- Education System

Estimate 40,000 to 70,000 hospital deaths

Higher cost & lower population health than other industrial nations

ACSI Score for Hospitals at 70% Lower Than IRS E-filers & VA Healthcare System

High Performance Healthcare System.
Driving Forces of Change

Input

- Health Reform
- State Budgets
- Estimated 40,000 to 70,000 hospital deaths
- Growing Chronic Illness
- Slow Economic Recovery

Resources

- National Debt
- Lower Performance Than other Nations
- $2.2 Trillion In Healthcare
- 16.2% of GDP
- VA Healthcare
- >1200 State Health Departments
- Medical Schools
- 5,815 Community Hospitals
- 2.3 Million Physician Offices
- Federal & State Governments
- Congress
- Governors
- President
- 16.6 Million Healthcare and Social Services Employees

Guidelines & Models

- Partnership for Patients
- ACO
- IOM Priorities
- CMS Demonstrations
- Kaiser Foundation
- Industrialized Nations
- HMO
- IHI –Focus Areas
- Leepfrog

People
Input

Environmental Factors:
- Health Reform
- State Budgets
- Estimated 40,000 to 70,000 hospital deaths
- Growing Chronic Illness

Resources:
- US HHS
- US CDC
- VA Healthcare
- >1200 State Health Departments
- Medical Schools

Industries:
- HMO
- IHI –Focus Areas
- Leepfrog

Professionals:
- President
- Congress
- Governors
- Federal & State Governments

Organizations:
- Commonwealth Fund
- Kaiser Foundation
- Industrialized Nations

Guidelines & Models:
- Guidelines & Models

Partnership for Patients

Healthcare and Social Services Employees:
- 16.6 Million
Aim and Purpose of the Your State Flex Program: A Subsystem of Medicare Rural Flex Program

Support Local Rural Providers
Improve the Performance of Rural Providers
Promote the Value of Rural Providers
Support Local Rural Providers. Improve the performance of the Rural Providers. Promote the value of Rural Providers.

**Aim and Purpose of the System**
Aim and Purpose of the System

Support Local Rural Providers. Improve the performance of the Rural Providers. Promote the value of Rural Providers.
• Patient Registrations: 1,786,841
• Emergency Patients: 289,399
• Urgent Care: 95,320
• Outpatient Infusion: 30,326
• Inpatient Discharges: 25,840
• Transfers to another Hospital: 12,568
• Observation Patients: 10,402
Aim and Purpose of the MICAH Quality Network System: a subsystem of Michigan Center for Rural Health

Support Local Quality Leaders
Improve the performance of the Member CAHs
Promote the Value of CAHs in the Continuum of Care
Support Local Quality Leaders. Improve the performance of the CAH Members. Promote the value of CAH in the continuum of care.
System Map of: MICAH Quality Network

**Input**
- Environment
- Equipment
- Guidelines & Models
- People

**Processes**
- Structured Meetings
- Communicate to CAH
- Measure Development
- Data Reporting
- Benchmarking
- Best Practice Review
- Recognition Program
- Annual CAH Survey

**Outputs**
- Web Data Reporting
- QCAH List-serve
- Finance Support for QA Software & HCAHPS
- Export Data to CMS, MHA Transparency, BCBS P4P
- Member Specific Quality Reports with Benchmarking
- Quarterly Newsletter
- Annual Awards Program
- MICAH Transfer Measures

**Customers**
- Patients
- Hospital CEOs
- MPRO
- MHA
- Leapfrog
- CMS
- HRSA
- Executive Committee
- Committee Members
- MCRH CAH Liaison
- BCBS

**MCRH, State Office of Rural Health**
Provides Flex/SHIP Grant Funding & Staff Support
System Map of: MICAH Quality Network

Input
- Environment
- Equipment
- Guidelines & Models
- People

Processes
- Structured Meetings
- Communicate to CAH
- Measure Development
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- Annual CAH Survey

Output Feedback
- Process Feedback
- Output Feedback

Outputs
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MPRO, CMS-QIO Provides Quality Consultation & Annual Award Support
System Map of: MICAH Quality Network

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- BCBS

**MHA, Core Options Data Vendor**
Provides Data Definition and Submission Support to CMS, BCBS P4P
## Hospital Compare Quality Measures
### 2009 National and State Specific Report

<table>
<thead>
<tr>
<th></th>
<th>Number of CAHs</th>
<th>Inpatient Data</th>
<th>Outpatient Data</th>
<th>HCAHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Michigan</strong></td>
<td>35</td>
<td>22 (62.9%)</td>
<td>8 (22.9%)</td>
<td>16 (45.7%)</td>
</tr>
<tr>
<td><strong>National</strong></td>
<td>1,312</td>
<td>943 (71.9%)</td>
<td>209 (15.9%)</td>
<td>465 (35.4%)</td>
</tr>
</tbody>
</table>
“In the future, as reimbursement is linked to quality, it will be even more important for CAHs to be able to document the quality of care they provide.”

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