Quality Reporting
What does it all mean?
Angie Charlet, RN, MHA
Director of Quality and Education
ICAHN
Quality

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

*Institute of Medicine (IOM)*
2005 IOM Report:
Quality Through Collaboration: The Future of Rural Health Care

5 pronged strategy to address the quality challenges in rural communities:

1. Adopting an integrated approach to addressing both personal and population health needs;
2. Establishing a stronger health care quality improvement support structure to assist rural health systems and professionals;
3. Enhancing the human resource capacity of health care professionals in rural communities, and the preparedness of rural residents to actively engage in improving their health and health care;
4. Assuring that rural health care systems are financially stable; and
5. Investing in an information and communications technology (ICT) infrastructure, which has enormous potential to enhance health and health care over the coming decade.
Quality Reporting Measures

- Hospital Quality Reports
- Governing Bodies (CMS, Joint Commission, etc.)
- Vendor requirements
- State Requirements (nurse staffing)
- NDNQI
- NHSN
- QIO
- Benchmarking projects (HEN, BOOST, Project Red, P4P)
- MBQIP
- iVantage
- Etc.....
## Appendix A: Quality Measure Reporting Tools for CAHS

<table>
<thead>
<tr>
<th>Data Reporting Channel</th>
<th>Type of Data Submitted</th>
<th>Submission Method</th>
<th>Mandatory or Voluntary</th>
<th>Public Reporting Entity (Where Data Ends Up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIO Clinical Warehouse</td>
<td>Hospital IP Quality Reporting Program: PN, HR, AMI, SCIP</td>
<td>Information abstracted by hospital and submitted electronically: 1. Via CART Tool thru Qnet or 2. Vendor such as IHA/COMPdata</td>
<td>Voluntary for CAH</td>
<td>Hospital Compare (Website hosted by CMS) IL Hospital Report Card (HRC) IHA Transparency Website TJC Quality Reports</td>
</tr>
<tr>
<td></td>
<td>Hospital OP Quality Reporting Program: OP Surg, Chest pain, AMI</td>
<td></td>
<td></td>
<td>Hospital Compare</td>
</tr>
<tr>
<td>Data taken from Medicare Claims submitted for payment by hospital</td>
<td>OIE: Outpatient Imaging Efficiency Measures OP8 - OP 25 (See Qnet for entire listing)</td>
<td>Claims based data; extracted from billing; not abstracted by hospital</td>
<td>Voluntary for CAH; if report Hospital OP Quality Data Public then Illinois measures show up</td>
<td>Hospital Compare</td>
</tr>
<tr>
<td>IHA COMPedata Website or IDPH site</td>
<td>Nurse Staffing Information: Nursing hrs/patient day (RN, LPN, and Assistive Nurs) and total IP days.</td>
<td>Data entered on Compaydata Website</td>
<td>Mandatory per HRCA (Hospital Report Card Act)</td>
<td>HRC</td>
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<tr>
<td>IHA COMPedata Website</td>
<td>Surgical Care Improvement Project (SCIP)</td>
<td>Information abstracted by hospital and submitted to: IHA COMPedata electronic file transfer</td>
<td>Mandatory for Illinois</td>
<td>Hospital Compare</td>
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<tr>
<td>NHSN (National Health Safety Network) to CDC/IDPH</td>
<td>CLABSI</td>
<td>NHSN reporting system</td>
<td>Illinois Mandate</td>
<td>HRC</td>
</tr>
<tr>
<td>NHSN to CDC/IDPH</td>
<td>SSI Total Knees</td>
<td>NHSN reporting system</td>
<td>Illinois Mandate</td>
<td>HRC</td>
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<tr>
<td>NHSN to CDC/IDPH</td>
<td>MRSA</td>
<td>NHSN reporting system</td>
<td>Illinois Mandate starting January 2012</td>
<td>HRC</td>
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<td>NHSN to CDC/IDPH</td>
<td>VAP</td>
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<td>Illinois Mandate planned (2013)</td>
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<td>NHSN to CDC/IDPH</td>
<td>CAUTI</td>
<td>NHSN reporting System</td>
<td>Illinois Mandate planned (2014)</td>
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<tr>
<td>Data taken from Medicare Claims submitted for payment by hospital and UB Administration data</td>
<td>Readmission Rates</td>
<td>Claims based data - not abstracted by hospital</td>
<td>NA</td>
<td>Hospital Compare</td>
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<tr>
<td>Data taken from Medicare Claims submitted for payment by hospital and UB Administration data</td>
<td>Mortality Rates</td>
<td>Claims based data - not abstracted by hospital</td>
<td>NA</td>
<td>Hospital Compare, HRC IHA Transparency Website</td>
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<tr>
<td>CMS: Attestation required</td>
<td>Meaningful Use</td>
<td>Voluntary - Incentive payment</td>
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<tr>
<td>IHA COMPdata Website</td>
<td>UB Administrative Data (Consumer Guide)</td>
<td>Electronic submission via COMPdata Website</td>
<td>Mandatory</td>
<td>Agency for Healthcare Research and Quality Indicators (AHRQ) Hospital Compare HRC IHA Transparency Website</td>
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<td>Federal Office of Rural Health Policy will access data submitted to Hospital Compare by the hospital</td>
<td>MBIQIB (Medicare Beneficiary Quality Improvement Project)</td>
<td>NA</td>
<td>Voluntary (all 51 Illinois CAHs have signed commitment letters to report)</td>
<td>Federal Office of Rural Health Policy</td>
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<tr>
<td>IDPH designated site</td>
<td>Cancer Registry</td>
<td>Reporting system</td>
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<td>IDPH designated site</td>
<td>Trauma Registry</td>
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<td>IDPH designated site</td>
<td>EDAP or SEDP designation</td>
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<tr>
<td>IDPH designated site</td>
<td>Perinatal Indicators</td>
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<tr>
<td>Joint Commission</td>
<td>Core Measures</td>
<td>Vendor submission method</td>
<td>Mandatory to collect and track but do not have to submit. Only verify during survey.</td>
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<tr>
<td>Joint Commission</td>
<td>National Patient Safety Goals</td>
<td>Vendor submission method</td>
<td>Mandatory to collect and track but do not have to submit. Only verify during survey.</td>
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<tr>
<td>CMS</td>
<td>OASIS Quality Measures for Home Health</td>
<td>Electronic submission via CMS download</td>
<td>Mandatory for all Medicare-certified Home Health Agencies CASPER on CMS site and Home Health Compare site.</td>
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<td>Varies - Electronic Health Record, PQRS, HEDIS, Joint Commission</td>
<td>Medicaid Measures</td>
<td>Electronic Health Record</td>
<td>Voluntary (9/2012) As submitted to</td>
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<tr>
<td>Qualified vendors and EHR vendors</td>
<td>Physician Quality Reporting (PQRS)</td>
<td>Claims registry, EHR, DM Measures Group (C/R),</td>
<td>Voluntary - Incentive payment</td>
<td>Various depending on measure.</td>
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<td>IHA</td>
<td>Project RED/BOOT</td>
<td>IHA submission method</td>
<td>Voluntary</td>
<td>Only to those participating in projects.</td>
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<td>QIO</td>
<td>Pharmacy/CAUTI Improvement Projects</td>
<td>QIO submission method</td>
<td>Voluntary</td>
<td>Only to those participating in projects.</td>
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<td>NDNQI Tool</td>
<td>Nursing Indicators</td>
<td>Electronic on NDNQI site</td>
<td>Voluntary</td>
<td>Only to those involved in organization.</td>
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<tr>
<td>ICAHN Scorecard</td>
<td>ICAHN</td>
<td>Manually into ICAHN scorecard</td>
<td>Voluntary</td>
<td>To ICAHN members</td>
</tr>
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</table>
Governing Board Role in Quality Management

- Dynamic and collaborative partnership
- Commitment
- Joint Commission and CMS
- Identify quality reports and purpose
- Know that quality is a daunting task that is ever-changing
Questions to ask yourselves: components to your internal quality platform

• How has the hospital defined quality?
• Do our hospital’s vision, mission statement and strategic plan incorporate a commitment to quality?
• How does our institution determine who its customers are and what aspects of quality are important?
CMS Medicare Conditions of Participation (CoP)

- Established the quality and safety standards that all US hospitals must follow
- Require Governing Boards ensure that there is an effective hospital-wide quality assurance program to evaluate the provision of patient care
- No specific quality management strategy or approach is mandated
Medicare CoP: Quality Assurance and Performance Improvement Standard

- Program Scope
- Program Data
- Program Activities
- Performance Improvement projects
- Executive Responsibilities
CoP Scope

• Must include, but not limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.

• Must measure, analyze, and track quality indicators, including adverse patient events, and others aspects of performance that assess processes of care, hospital service and operations.
CoP: Data

• Must incorporate quality indicator data including patient care data, and other relevant data: ie information either sent to or from QIO (Hospital Compare)
• Must use the data collected to:
  – Monitor the effectiveness and safety of services and quality of care
  – Identify opportunities for improvement and changes that will lead to improvement
• Frequency of the data collection must be specified by the hospital’s governing body
CoP: Program Activities

• Must set priorities for its performance improvement that
  – Focus on high-risk, high-volume, or problem-prone areas; and
  – Consider the incidence, prevalence and severity of problems in those areas; and
  – Affect health outcomes, patient safety, and quality of care

• Must track medical errors and adverse patient events, analyze their causes, and implement actions

• Must take actions aimed at performance improvement and track to ensure improvements are sustained
CoP: Performance Improvement Projects

- The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital’s services and operations.
- May, as one project, develop and implement an information technology system.
- Must document what quality improvement projects are being conducted, the reasons for these projects and the measurable progress achieved.
- Not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.
CoP: Executive responsibility

- Ongoing program for quality improvement and patient safety
- All efforts address priorities for improved quality of care and patient safety; and all actions are evaluated
- Hospital-wide assessment and PI efforts address priorities for improved quality of care and patient safety
- Clear expectations for safety are established
- Adequate resources are allocated
- Determination of the number of distinct improvement projects is conducted annually
Key Components of a Quality Improvement Program

• Knowledge of the science of quality and safety improvement
• Clinical knowledge and the tools needed to apply this knowledge (include computer-aided decision support)
• Standardized performance measures
• Performance measures and data feedback capabilities
• Quality improvement processes and resources

• Source: *Adapted from Brent James, IOM Workshop Presentation 2003
Quality Indicators: Pull it together

- Measure of an important aspect of the care or services
- Types of Quality Indicators
  - Efficiency/Structural
  - Process
  - Outcome
Efficiency/Structural

Assesses whether the hospital has the capability and resources to provide high-quality patient care

- Appropriate staffing levels
- Equipment standards
- Safety codes being met
- Wait time in the ED
Process Indicators

Measure whether the right actions were taken to achieve optimal care (outcomes) “doing the right thing”

- Antibiotic prior to surgery to prevent infection
- Heart attack patient receiving medications
- Hand-washing initiatives
Outcome Indicators

Answer the question, “Did the patient get better?”

- Deaths within 24 hours of admission
- Surgical site infection rate
Scope of Indicators

- Hospital-wide
  - ie. Readmissions within 30 days of discharge
- Departmental
  - ie. Vaginal births following previous cesarean delivery
- Individual occurrence
  - Adverse or unusual events
Quality Reporting to Board

Not responsibility of board to complete each step but rather ensure that the steps were completed

– Assign responsibility
– Delineate the scope of care and service
– Identify important aspects of care and service
– Establish thresholds for evaluation
– Collect and organize data
Quality Reporting cont

- Initiate evaluation
- Take actions to improve care and services
- Assess effectiveness of the actions and ensure that improvement is maintained
- Communicate results to relevant individuals and groups
Performance Improvement Activities

- Should discuss the activities to be included in every performance improvement effort
- Do not need to know the specific activities but ensure that all the functions occur regularly and any follow up is taken
- Trends or patterns over time should be noted and compared with national or local standards with data from similar hospitals
Hospital-wide Activities

• Quality performance indicators
• Infection control
• Safety and security
• Utilization management and volume statistics
• Patient, employee and physician satisfaction
Collecting Data

- What is Data Collection?
- Data Collection is obtaining useful information
- The issue is not: How do we collect data?
- It is: How do we obtain useful data?
Why Collect Data?

To establish a factual basis for making decisions

– I think the problem is....

Then becomes

– The data indicate the problem is....
Making a Data Collection Plan

• Why do we want the data?

• What purpose will they serve?

• Formulate your change statement:
  If..... Then.....
Making a Data Collection Plan

• Who will collect the data?

• Workers who perform the process steps
  – Properly trained
  – Provided with resources
Making a Data Collection Plan

How do we collect the right data?

- Small sample sizes
- Collect frequently
- Dependent on availability of data, cost, consequences
<table>
<thead>
<tr>
<th><strong>Population</strong></th>
<th><strong>Sample</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If less than 30</td>
<td>100%</td>
</tr>
<tr>
<td>30-100</td>
<td>30 cases</td>
</tr>
<tr>
<td>101-500</td>
<td>50 cases</td>
</tr>
<tr>
<td>greater than 500</td>
<td>70 cases</td>
</tr>
</tbody>
</table>
Data Collection Problems

Failure to establish Operational Definitions

- When and how often to collect data
- How to collect data
- Units of measurement
- Criteria for defects
- Handling of multiple defects
Data Collection Problems

Adding bias to the collection process
- Slowdown or speedup
- Fear
- Errors in procedures
- Missing data
Uses for Check-sheets

- Record data for further analysis
- Provide historical record
- Introduce Data Collection methods
Making a Useful Check-sheet

• Tailored for specific purpose
• Workers help develop form
• Columns labeled clearly
• User-friendly format
What specifically is benchmarking?

• “A standard by which something can be measured or judged” (Webster’s)
• A means of comparing process and performance with others of similar specialty
• High performer “best practices” raises the bar
Let’s Benchmark!

Why is benchmarking so important?

– Provides a structured approach to data gathering and analysis
– Assists management to develop optimal strategic and operational decisions
– Quantifies measures of performance
– Quantifies the gap between your organization and best practice
– Encourages innovation and creative thinking
Benchmarking for improved performance

- Quality
- Patient Satisfaction
- Reliability
- Effectiveness
- Efficiency
- Patient care outcomes
Types of Benchmarking

• Intrinsic Benchmarking

• Extrinsic Benchmarking
Intrinsic Benchmarking

• Looking for the best within your organization or like organizations.
  – Hospital departments and patient care units benchmarking with one another
  – Hospitals benchmarking against like Hospitals
  – Nursing homes benchmarking against like nursing homes
  – Clinics benchmarking with other clinics
Extrinsic Benchmarking

Looking for best practices outside commonly known environments

– Hospitals learning guest relations practice from the hotel industry
– Hospital-based labs learning efficiencies of free-standing laboratories
– Hospital-based swing bed units learning skilled care from long term care facilities
Key Considerations in Benchmarking

• Never stop at data comparison
• Focus on a particular work process; the goal is rarely to change your entire process
• Look for the practices, enablers and variations in the other processes that make the outcomes of your processes stronger than what you can currently achieve
• Never be afraid to borrow great ideas if they strengthen patient care and operations
Objective

• The over-riding objective of benchmarking is to identify and learn about best practices.
• Unless we implement the best practices, we have engaged in nothing more than an intellectual exercise with little value.
• For benchmarking to have value, it must be put to work improving your organizational performance
<table>
<thead>
<tr>
<th>Measure</th>
<th>2009Q3</th>
<th>2009Q4</th>
<th>2010Q1</th>
<th>2010Q2</th>
<th>2010Q3</th>
<th>2010Q4</th>
</tr>
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<tbody>
<tr>
<td><strong>PN-2/PNE-5 Pneumococcal Vaccination</strong></td>
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</tr>
<tr>
<td>CAH Aggregate</td>
<td>85.98%</td>
<td>89.04%</td>
<td>88.27%</td>
<td>87.04%</td>
<td>87.76%</td>
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<td>91.62%</td>
<td>93.11%</td>
<td>92.89%</td>
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<td>94.21%</td>
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<tr>
<td>National Top 10% Benchmark</td>
<td>99.80%</td>
<td>99.80%</td>
<td>99.90%</td>
<td>99.90%</td>
<td>99.80%</td>
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<tr>
<td><strong>PN-3a/PNE-3a Blood Cultures Within 24 hours Prior to or After Hospital Arrival</strong></td>
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<tr>
<td>CAH Aggregate</td>
<td>82.61%</td>
<td>76.47%</td>
<td>73.91%</td>
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<td>91.67%</td>
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<tr>
<td><strong>PN-3b/PNE-3b Blood Cultures Before First Antibiotic</strong></td>
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<tr>
<td><strong>PN-4/PNE-6 Adult Smoking Cessation Advice/Counseling</strong></td>
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<td>CAH Aggregate</td>
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<td>100.00%</td>
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<tr>
<td><strong>PN-5c Initial Antibiotic Received Within 6 Hours of Hospital Arrival</strong></td>
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<td><strong>PN-6/PNE-2 Initial Antibiotic Selection for CAP in Immunocompetent Patient</strong></td>
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<td><strong>PN-7/PNE-4 Influenza Vaccination</strong></td>
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Benefits of Network Approach

- Bigger numbers
- Ask questions
- Share experiences
- Tool customization
- Learning opportunities
- New perspectives
- Best Practice sharing!

- True opportunity to USE the data you are collecting---not just report numbers
Our past experiences

• Internal scorecard from outside vendor
• Offered all benefits of network without national data
• Generated a repository of data: hospital specific and over time comparisons
Our challenges:

- Underutilized
- Poor graphing capability
- No one had taken the lead on data analysis
- No “solutions” to data abstraction
- No best practice sharing
- Did not drive organizational performance

We were experiencing the DRIP syndrome
Where Do We Go From Here?

- RFP for new vendor
  - State specific data collection
  - Ability to create meaningful graphs without difficulty
  - Create a forum to exchange best practices
  - Ability to benchmark against other states of like-size hospitals
QHi Benchmarking Practices

- **Clinical Quality**
- Healthcare Associated Infections per Patient Day
- Pneumonia Patients Given Antibiotics within 6 hours of admission - CMS PN-5c
  - Retired by CMS 1/1/12 – replacement TBD
- Pneumonia Patients Receiving Pneumonia Immunization - CMS PN-2
  - Retired by CMS 1/1/12 – will be replaced in QHi with CMS IMM-1b
- Unassisted Patient Falls
- Employee Contribution
- Benefits as a Percentage of Salary
- Staff Turnover
- **Financial Operational**
- Gross Days in AR
- Days Cash on Hand - April 2009
Additionally, facilities can select from over 90 measures in the QHi library of indicators.

**Clinical Quality Measures**
- Healthcare Associated Infection rate*
- Unassisted Patient Falls *
- Inpatients Screened for Pneumonia
- Medication Omissions Resulting in Medication Error
- Medication Errors Resulting from Transcription Errors
- ER Provider Response Times
- Return ER Visits within 72 hours with same diagnosis
- Readmits Within 30 Days with Same or Similar Diagnosis

**CMS Heart Failure Measures**
- Discharge Instructions provided to HF patients - CMS HF-1
- Evaluation of LVS Function - CMS HF-2
- ACEI or ARB for LVSD - CMS HF-3
- Adult Smoking Cessation Advice/Counseling - CMS HF-4 – Retired by CMS 1/1/12

**CMS Pneumonia Measures**
- Inpatients Receiving O2 Assessment within 24 hours of admission - CMS Pn-1 - Retired by CMS
- Inpatients Receiving Pneumonia Immunization * - CMS Pn-2 Retired by CMS 1/1/12
- Pneumonia Given Antibiotics within 6 hours of admission * - CMS Pn-5c Retired by CMS 1/1/12
- Blood Cultures Performed in ED Prior to Initial Antibiotic Received in Hospital - CMS PN-3b
- Adult Smoking Cessation Advice/Counseling - CMS PN-4
- Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients - CMS PN6
- Influenza Vaccination - CMS PN-7 Retired by CMS 1/1/12
Quality Health Indicators

**Financial Operational**
Bad Debt Expense
Charity Care
Cost per Patient Day
Current Ratio
Days Cash on Hand *
Gross Days in AR *
Labor Hours per Patient Day
Net Patient Revenue per Patient Days
Operating Profit Margin - percent
Payer Mix - Commercial
Payer Mix - Medicaid
Payer Mix - Medicare
Payer Mix - Other
Payer Mix - Other Government
Payer Mix - Self/Private Pay

**Financial productivity-related measures**
Physical Therapy Labor Hours per Unit of Service
Laboratory Labor Hours per Unit of Service
X-Ray Labor Hours per Unit of Service
Mammogram Labor Hours per Unit of Service
Ultrasound Labor Hours per Unit of Service
CT Labor Hours per Unit of Service
MRI Labor Hours per Unit of Service
Pharmacy Labor Hours per Unit of Service
Nursing Hours per Patient Day
Rural Health Clinic Encounters per FTE
Long Term Care Hours per LTC Patient Day
Laboratory Hours per Billed Service

*QHi Core Measure Set*
Another benchmarking method: MBQIP

- Phase 1 Measures
  - Pneumonia Hospital Compare CMS Core Measure; and
  - Congestive Heart Failure Hospital Compare Core Measure
- Phase 2 Measures
  - Outpatient 1-7: Hospital Compare CMS Measure; and
  - HCAHPS
- Phase 3 Measures
  - Pharmacist CPOE/Verification of Medication Orders within 24 hours
  - Outpatient Emergency Department Transfer Communication
Conclusion

• Benchmarking is a valuable technique for quickly lifting the performance of an organization.

• It is not just an auditing practice but rather allowing continuous improvement and development.
Questions
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Contact

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