Working With Your Hospitals on Quality Improvement: From Small Steps to Large Leaps

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July 27th, 2009
If you have questions during the Q&A session, please use the Raise Hand function; you will be placed into a queue to ask your question.

To ask a question, click on the **Raise Hand** button in the Participants Panel and the Host will un-mute your line.

Once your question has been answered, please click the **Lower Hand** icon and the Host will mute your line.
Questions

We will have three opportunities throughout the Web conference for you to ask questions of our speakers. To do so, please:

- At any time, post your questions in the Q&A box on the right-hand side of your screen and press “send” to “all panelists”

  OR

- Click the “raise your hand” button to be unmuted and introduced to verbally ask a question
Agenda

- Welcome and Introduction
- Quality Improvement Overview
- Questions and Answers
- Dallas-Fort Worth Hospital Council Example
- Questions and Answers
- Pacific Business Group on Health Example
- Questions and Discussion
Orientation:
October - Designing Your Reporting Program

Measures/Data/Analysis:
November - Selecting Measures & Data
December - Key Choices in Analyzing Data for the Report
January - Classifying Hospitals

Reporting/Disseminating/Promoting:
February - Displaying the Data
March - Web Site Design & Content
April - Getting the Public To View and Use Your Report

Evaluation:
May - Evaluation of Public Reporting Program

Quality Improvement:
July - Working With Your Hospitals on Quality Improvement: From Small Steps to Large Leaps

Q&A Web Forum - August 12th
Poll Question

What is your organization’s experience with working on quality improvement with health care provider organizations? (Please choose one.)

- Some experience as it relates to our public report
- A lot of experience as it relates to our public report
- Some experience unrelated to our public report
- A lot of experience unrelated to our public report
- No experience
Today’s Learning Objectives

- Raise awareness of the opportunity to work on quality improvement with hospitals that appear in your public report.
- Understand hospitals’ capacities to engage in quality improvement related to areas measured in your report.
- Once a public report card is in place, understand strategies used by others to foster the spread of best practices among providers.
- Learn from case examples the cost/benefit associated with strategies for facilitating peer-to-peer learning.
Poll Results

Please find the poll results on the right-hand side of your screen.

- Some experience as it relates to our public report 41%
- A lot of experience as it relates to our public report 27%
- Some experience unrelated to our public report 5%
- A lot of experience unrelated to our public report 9%
- No experience 18%
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Seeing the Opportunity

- There will be opportunities to join with hospitals on quality improvement (QI) that you are publicly reporting on
  - Requests for assistance may be direct or indirect
  - You may want to offer assistance given your proximity to the data & quality measure results

- A chance to think about your organization’s role in QI prior to issuing your public report
  - How you would respond if asked for some help
  - Deciding what you may proactively want to provide in an ad hoc or systematic manner
Words/statements from hospitals may directly or indirectly provide an opportunity to work with hospitals on QI

- Direct: “Can you tell us what cases were in the numerator?”
- Indirect: “These results don’t tell us where we need to make improvements!”
Actions of hospitals may or may not fit the words
  - Statements made in the press and to the report card sponsor questioning how actionable the results are for QI
  - Meanwhile, hospitals are finding ways to make improvements in the areas measured in the report*

The upshot: Realize it’s a complex dialogue. It’s a dialogue that may be productive, for there is often QI work occurring on measures in your report

* Judith Hibbard et al: Health Affairs Mar/Apr ’03 & July/Aug ’05
Lessons learned from surveys conducted regarding QI in measures used in P4P may provide insights:

- Providers believed they lacked important resources for achieving the quality goals
- Some uncertainty as to whether provider organizations had the resources to achieve the quality measures
- Many thought the incentive wasn’t sufficient to offset the cost of making the needed investment in quality infrastructure

The upshot: Understand the hospitals position and identify QI methods with hospitals that reflect their infrastructure

* Gary Young et al: Health Care Financing Review, Fall '07
Varying Degrees of Engaging in QI with Hospitals

- The next few slides – and the next 2 presentations – provide a sampling of ideas for report card sponsors in working with hospitals on QI.

- These examples illustrate:
  - There’s not one “right” way to go about QI work. Finding a good fit calls for working locally with your provider community.
  - There’s a spectrum of the level of effort that can be expended. It’s not all or nothing.
Data & Results: Less Effort

- Compiling & reviewing results with hospitals
- Developing the results with the question in mind: “What are the measures with more room for improvement?”
  - Sharing results beyond what will be in your report, such as observed to expected rate
  - Walking through what the results mean… and don’t mean, e.g.:
    - What “less than expected” means
    - What “as expected” may not necessarily mean
Navigating across result tables with hospitals (especially in regard to composites)

In deciding how to navigate through the tables, consider the question: “What can this tell me about where the problem is occurring?”

- For example, for composites, it’s helpful to understand what’s contributing to the performance in the composite by having the performance in the indicators used in the composite

  - Again, sharing the observed & expected rates for each measure in the composite can shed some light on where to focus on improvement
For all hospitals, stratify their results by options provided within the AHRQ QI software, e.g.:

- Age category, quarter, risk category

AHRQ QI software offers three custom stratifiers beyond the canned options

Beyond the AHRQ QI software customized stratification, you can selectively pull data & send it through the AHRQ QI software, e.g., various AHRQ Clinical Classifications Software (CCS) groupings
Performing ad hoc analysis with the data & results, e.g.:
- Interpretation beyond providing results as noted in previous slides

Ad hoc data queries, e.g.:
- Pull each numerator claim for a given measure (if possible given one’s data use agreement)
Group Learning: Varying Effort

- **Once & done Webinars or in-person events**
  - Webinars likely to be preferable with smaller hospitals, rural areas, & dispersed hospitals
  - Use of national experts or leaders in a given community/State as presenters
  - Selecting topics by measures where greatest interest is expressed or most room for improvement

- **Ongoing or time limited groups**
  - Facilitate/foster interest groups that will work on a QI project that will span several months or years
High-Level QI Environmental Scan

- National QI resources, e.g.:
  - Institute for Healthcare Improvement
  - American Society for Quality – Health care division

- State/local QI resources, e.g.:
  - Quality Improvement Organizations
  - State Hospital Associations
  - Aligning Forces for Quality sites (in select areas)
  - Chartered Value Exchanges
QI toolkit under development for hospital use to make improvement related to the AHRQ IQIs & PSIs. Some specifics of the toolkit:

- Methods to evaluate the data for identifying opportunities for improvement
- Strategies for implementing interventions (or evidence-based best practices)
- Methods to measure progress

Available mid-2011
Questions

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Community, Patient Safety and Patient Quality

Dallas-Fort Worth Hospital Council Education and Research Foundation
Objectives

- Business Intelligence tool (customize data for hospitals’ use)
  - Share reports with individual hospitals
  - Hospitals pull their own data
  - Peer-to-peer improvement

- Patient Safety and Quality Improvement Committee
  - Use IQIs and PSIs for hospital improvement
    - Choose AHRQ QIs to analyze various trends
      (preselect, survey, by condition)
### DFWHC ERF Data

#### Data Initiative (DI) Hospital Data

- Agency for Healthcare Research and Quality (AHRQ) Quality Indicators
- Centers for Medicare and Medicaid Services (CMS) Quality Indicators

- **Data EXCLUSIVE to DFWHC DI Members**
  - **6,428,743 DI inpatient records from 1999**
    - Data available 90 days from close of quarter
  - **3,933,245 DI outpatient records from 2006**
    - Data available 120 days from close of quarter
  - **DI AHRQ Patient Safety Quality Indicators** *(PSI)*
  - **DI AHRQ Inpatient Quality Indicators** *(IQI)*
  - **DI AHRQ Pediatric Indicators** *(PDI)*

- **CMS Quality Indicators** for participating hospitals

- **Other Data Available to DFWHC DI Members**
  - **20,884,268 THCIC inpatient records from 2000**
    - Data available 274 – 365 days from close of quarter
  - **THCIC AHRQ Patient Safety Indicators** *(PSI)*
  - **THCIC AHRQ Inpatient Quality Indicators** *(IQI)*
  - **THCIC AHRQ Pediatric Quality Indicators** *(PDI)*

* = As of December 2008

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DFWHC ERF 2009
Location of All Participants

Green = rural
Red = critical access
Blue = DFWHC (urban)
### Outpatient ER Visit – Abdominal Pain NYU Categories [n = 1,250]

<table>
<thead>
<tr>
<th>NYU-ED(%Total) as values</th>
<th>ED1(%Total) Non-Emergent</th>
<th>ED2(%Total) Emergent-PC Care</th>
<th>ED3(%Total) Emergent-ED Care-Prev</th>
<th>ED4(%Total) Emergent-ED Care-Not Prev</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdom hernia</td>
<td>53.0%</td>
<td>22.1%</td>
<td>0.0%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>0.0%</td>
<td>67.0%</td>
<td>0.0%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Ac retn fail</td>
<td>0.0%</td>
<td>55.3%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Acute CVD</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Acute MI</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Adlt resp fl</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Allergy</td>
<td>50.7%</td>
<td>27.2%</td>
<td>0.0%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Anal/rectal</td>
<td>21.2%</td>
<td>15.2%</td>
<td>0.0%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Anemia</td>
<td>50.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>33.3%</td>
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<tr>
<td>Appendicitis</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>0.0%</td>
<td>1.9%</td>
<td>98.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Back problem</td>
<td>45.5%</td>
<td>20.2%</td>
<td>0.0%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Biliary dx</td>
<td>19.5%</td>
<td>20.0%</td>
<td>0.0%</td>
<td>60.5%</td>
</tr>
<tr>
<td>Blindness</td>
<td>0.0%</td>
<td>50.0%</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Bniqnt ut neo</td>
<td>66.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Breast dx</td>
<td>78.6%</td>
<td>21.4%</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
<td>Bronchitis</td>
<td>4.3%</td>
<td>75.2%</td>
<td>16.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Cardia arrst</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Chest pain</td>
<td>0.0%</td>
<td>47.9%</td>
<td>0.0%</td>
<td>52.1%</td>
</tr>
<tr>
<td>Chf</td>
<td>0.0%</td>
<td>4.0%</td>
<td>96.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Obesity</td>
<td>25.0%</td>
<td>15.9%</td>
<td>0.0%</td>
<td>74.1%</td>
</tr>
</tbody>
</table>
Agency for Healthcare Research and Quality

Inpatient Quality Indicators
Patient Safety Indicators
Pediatric Quality Indicators

N = 52
AHRQ Patient Safety Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Per 1000 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Puncture or Laceration</td>
<td></td>
</tr>
<tr>
<td>Birth Trauma - Injury to Neonate</td>
<td></td>
</tr>
<tr>
<td>Complications of Anesthesia</td>
<td></td>
</tr>
<tr>
<td><strong>Death among Surgical Inpatients w/ Complications</strong></td>
<td></td>
</tr>
<tr>
<td>Death in Low Mortality DRGs</td>
<td></td>
</tr>
<tr>
<td>Decubitus Ulcer Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Iatrogenic Pneumothorax Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Obstetric Trauma - Cesarean Section Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Obstetric Trauma - Vaginal w/ Instrument Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Obstetric Trauma - Vaginal w/o Instrument Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Post-Op Hemorrhage or Hematoma</td>
<td></td>
</tr>
<tr>
<td>Post-Op Hip Fracture Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Post-Op Physiologic and Metabolic Derangements Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Op Pulmonary Embolism or Deep Vein Thrombosis</strong></td>
<td></td>
</tr>
<tr>
<td>Post-Op Respiratory Failure Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Post-Op Sepsis Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Post-Op Wound Dehiscence Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Selected Infections Due to Medical Care Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Transfusion Reaction Per 1000 cases</td>
<td></td>
</tr>
<tr>
<td>Comp: Patient Safety for Selected Indicators</td>
<td></td>
</tr>
</tbody>
</table>

N = 19 indicators and 1 composite score
Hospital XYZ, AHRQ Death Among Surgical Patients With Complications Risk Adjusted Rate per 1,000 Cases Compared to Peers

Could “Drill-thru” to these records

Hospital XYZ [designated with arrow] and key peer hospitals

DFWHC ERF 2009
CMS Quality Indicators

Compliance Rates
## Comparative CMS Indicator Compliance Rates

<table>
<thead>
<tr>
<th>CMS Quality Indicators New</th>
<th>Rate of Compliance</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Date / Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate of Compliance as values</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AMI Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI ACEI or ARB for LVSD</td>
<td></td>
<td>88.04%</td>
<td>89.61%</td>
<td>95.55%</td>
<td>90.86%</td>
</tr>
<tr>
<td>AMI Adult Smoking Cessation Advice/Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI Aspirin at Arrival</td>
<td></td>
<td>94.99%</td>
<td>97.20%</td>
<td>97.14%</td>
<td>98.53%</td>
</tr>
<tr>
<td>AMI Aspirin Prescribed at Discharge</td>
<td></td>
<td>95.66%</td>
<td>96.27%</td>
<td>96.44%</td>
<td>96.40%</td>
</tr>
<tr>
<td>AMI Beta Blocker at Arrival</td>
<td></td>
<td>90.47%</td>
<td>94.44%</td>
<td>95.21%</td>
<td>93.28%</td>
</tr>
<tr>
<td>AMI Beta Blocker Prescribed at Discharge</td>
<td></td>
<td>93.82%</td>
<td>95.97%</td>
<td>97.20%</td>
<td>95.68%</td>
</tr>
<tr>
<td>AMI Primary Percutaneous Coronary Intervention Received Within 120 Minutes of Hospital Arrival</td>
<td></td>
<td>/0</td>
<td>65.14%</td>
<td>75.61%</td>
<td>72.13%</td>
</tr>
<tr>
<td>AMI Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival</td>
<td></td>
<td>/0</td>
<td>44.44%</td>
<td>22.22%</td>
<td>29.63%</td>
</tr>
<tr>
<td><strong>AMI Class</strong></td>
<td></td>
<td><strong>93.50%</strong></td>
<td><strong>95.05%</strong></td>
<td><strong>95.76%</strong></td>
<td><strong>94.81%</strong></td>
</tr>
<tr>
<td><strong>Heart Failure Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Failure ACEI or ARB for LVSD</td>
<td></td>
<td>87.81%</td>
<td>90.42%</td>
<td>92.92%</td>
<td>90.28%</td>
</tr>
<tr>
<td>Heart Failure Adult Smoking Cessation Advice/Counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Failure Discharge Instructions</td>
<td></td>
<td>/0</td>
<td>70.29%</td>
<td>78.48%</td>
<td>75.76%</td>
</tr>
<tr>
<td>Heart Failure LVF Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heart Failure Class</strong></td>
<td></td>
<td><strong>89.66%</strong></td>
<td><strong>88.41%</strong></td>
<td><strong>88.42%</strong></td>
<td><strong>88.73%</strong></td>
</tr>
<tr>
<td><strong>Pneumonia Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia Adult Smoking Cessation Advice/Counseling</td>
<td></td>
<td>/0</td>
<td>93.46%</td>
<td>94.31%</td>
<td>94.10%</td>
</tr>
<tr>
<td>Pneumonia Appropriate Initial Antibiotic Selection</td>
<td></td>
<td>/0</td>
<td>86.92%</td>
<td>90.19%</td>
<td>89.32%</td>
</tr>
<tr>
<td>Pneumonia Blood Culture Performed in Emergency Department Before First Antibiotic Received in Hospital</td>
<td></td>
<td>/0</td>
<td>91.03%</td>
<td>90.78%</td>
<td>90.84%</td>
</tr>
<tr>
<td>Pneumonia Influenza Vaccination Status</td>
<td></td>
<td>/0</td>
<td>76.06%</td>
<td>86.05%</td>
<td>82.78%</td>
</tr>
<tr>
<td><strong>Pneumonia Initial Antibiotic Received Within 4 Hours of Hospital Arrival</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DFWHC ERF 2009
Member Reports: Individual and Comparative

Knee Replacement

Hip Replacement
# AHRQ PSI # 12 Drill-Through Report for Hospital A

<table>
<thead>
<tr>
<th>Unique ID per Discharge</th>
<th>Patient ZIP Code</th>
<th>Age Description</th>
<th>Gender</th>
<th>Mortality</th>
<th>Length of Stay</th>
<th>TOTALCHG</th>
<th>Attending ID - Name</th>
<th>Operating ID - Name</th>
<th>Product Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>1384121X X000X</td>
<td></td>
<td>80-84 Years</td>
<td>Female</td>
<td>0</td>
<td>29</td>
<td>$244,586</td>
<td>K4550 -</td>
<td>Orthopedics</td>
<td></td>
</tr>
<tr>
<td>1384161X X000X</td>
<td></td>
<td>80-84 Years</td>
<td>Female</td>
<td>0</td>
<td>30</td>
<td>$533,029</td>
<td>GS202 -</td>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td>1384215X X000X</td>
<td></td>
<td>85-89 Years</td>
<td>Male</td>
<td>1</td>
<td>15</td>
<td>$270,789</td>
<td>GS202 -</td>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td>1384394X X000X</td>
<td></td>
<td>60-64 Years</td>
<td>Female</td>
<td>0</td>
<td>4</td>
<td>$38,051</td>
<td>L8999 -</td>
<td>Vascular Surgery</td>
<td></td>
</tr>
<tr>
<td>1384309X X000X</td>
<td></td>
<td>55-59 Years</td>
<td>Female</td>
<td>0</td>
<td>7</td>
<td>$162,054</td>
<td>K3777 -</td>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td>1384374X X000X</td>
<td></td>
<td>75-79 Years</td>
<td>Male</td>
<td>0</td>
<td>28</td>
<td>$208,308</td>
<td>H5857 -</td>
<td>General Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRG Expanded</th>
<th>APRDRG Expanded</th>
<th>Severity Score - Description</th>
<th>Primary Pay</th>
<th>Acquired Immune Deficiency Syndrome</th>
<th>Alcohol Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>480 - Hip &amp; femur procedures except major joint w MCC</td>
<td>308-Hip &amp; Femur Procedures for Trauma Except Joint Replacement</td>
<td>4-Extreme</td>
<td>Unknown</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>003 - ECMO or trach w MV 96 + hrs or PDX exc face, mouth &amp; neck w maj O.R.</td>
<td>004-Tracheostomy w/ Long Term Mechanical Ventilation w/ Extensive Procedure</td>
<td>4-Extreme</td>
<td>Medicare Part A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>414 - Cholecystectomy except by laparoscope w/o c.d.e. w MCC</td>
<td>262-Cholecystectomy Except Laparoscopic</td>
<td>4-Extreme</td>
<td>Unknown</td>
<td>0</td>
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</tr>
<tr>
<td>252 - Other vascular procedures w MCC</td>
<td>173-Other Vascular Procedures</td>
<td>3-Major</td>
<td>Medicare Part A</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>003 - ECMO or trach w MV 96 + hrs or PDX exc face, mouth &amp; neck w maj O.R.</td>
<td>005-Tracheostomy w/ Long Term Mechanical Ventilation w/ Extensive Procedure</td>
<td>4-Extreme</td>
<td>Medicare Part A</td>
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<td>0</td>
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<td>853 - Infectious &amp; parasitic diseases w O.R. procedure w MCC</td>
<td>720-Septicemia &amp; Disseminated Infections</td>
<td>4-Extreme</td>
<td>Medicare Part A</td>
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DFWHC ERF 2009
### Hip Replacement Counts with Complication Rates by Hospital and Physician 2007Q4 – 2008Q3

<table>
<thead>
<tr>
<th>Discharge Quarter</th>
<th>Participating Hospital</th>
<th>Attending Physician ID</th>
<th>Attending Name - ID</th>
<th>Unique ID per Discharge</th>
<th>Case Count</th>
<th>DVT Count</th>
<th>DVT Rate</th>
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<td>12345</td>
<td>Jane Doe - 12345</td>
<td>14439531</td>
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<td></td>
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<td>67890</td>
<td>John Doe - 67890</td>
<td>14441193</td>
<td>3</td>
<td>1</td>
<td>33.3%</td>
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<tr>
<td></td>
<td>Hospital X</td>
<td>14982</td>
<td>Doctor Smith - 14982</td>
<td>14439893</td>
<td>3</td>
<td>1</td>
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<td></td>
<td>Hospital X</td>
<td>14982</td>
<td>Doctor Smith - 14982</td>
<td>14440610</td>
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<td>0</td>
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<tr>
<td></td>
<td>Hospital X</td>
<td>14982</td>
<td>Doctor Jones - 54321</td>
<td>14438802</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
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<td></td>
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<td>54321</td>
<td>Doctor Jones - 54321</td>
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<td></td>
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<td>54321</td>
<td>Doctor Jones - 54321</td>
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<tr>
<td></td>
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<td>80802</td>
<td>Doctor Bob - 80802</td>
<td>14567735</td>
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<td>0.0%</td>
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<tr>
<td></td>
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<td>80802</td>
<td>Doctor Bob - 80802</td>
<td>14568008</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td></td>
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<td>19125</td>
<td>Doctor XX - 19125</td>
<td>14567753</td>
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<td>0</td>
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<tr>
<td></td>
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<td>19125</td>
<td>Doctor XX - 19125</td>
<td>14567753</td>
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<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Hospital Y</td>
<td>00552</td>
<td>Doctor XXX - 00552</td>
<td>14567735</td>
<td>2</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Hospital Y</td>
<td>00552</td>
<td>Doctor XXX - 00552</td>
<td>14568008</td>
<td>2</td>
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<tr>
<td></td>
<td>2008Q3</td>
<td></td>
<td></td>
<td>1,399</td>
<td>12</td>
<td>0</td>
<td>0.9%</td>
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</table>

Total: 5,687 cases
Member Dashboards: System- and Hospital-Level

Hip Replacement
Deep Vein Thrombosis and Pulmonary Embolism Cases from Hip Replacement Procedures

Rate Numerator: 415.11 Iatrogenic pulmonary embolism and infarction, 415.19 Other, 453.40-453.42 Venous embolism and thrombosis of deep vessels of distal lower extremity
Rate Denominator: 81.51 Total hip replacement, 81.52 Partial hip replacement, 81.54 Total knee replacement
Regional Enterprise Master Patient Index

Hip Replacement Admissions and Readmission Characteristics
Readmit Status of Total Hip Replacement with DVT Complication

Admitted for total hip replacement procedure

First admission in Regional Enterprise Master Patient Index

Principal Diagnosis

Diagnosis Position 2: 453.41
Venous embolism and thrombosis of deep vessels of proximal lower extremity

V57.89 = Other specified rehabilitation procedure, multiple training or therapy
### Readmit Status of Total Hip Replacement without Complication(s)

<table>
<thead>
<tr>
<th>Unique ID</th>
<th>REMPI</th>
<th>ReAdmit Facility</th>
<th>Admission Date</th>
<th>PRINDIAG</th>
<th>Diagnosis Description</th>
<th>ReAdmission Day Group</th>
<th>Date of Death</th>
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<td>Hospital A</td>
<td>2004-06-05</td>
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<td>296.33</td>
<td>RECURR MAJOR DEPRESSIVE SEVERE</td>
<td>Over 90 Days</td>
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<tr>
<td>333333333</td>
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<td>Hospital B</td>
<td>2004-09-14</td>
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<td>PNEUMONIA ORGANISM UNSPEC</td>
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<td>666666666</td>
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<td>Hospital B</td>
<td>2005-06-23</td>
<td>965.4</td>
<td>POISON AROM ANALGESICS OTH</td>
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<tr>
<td>888888888</td>
<td>1234567</td>
<td>Hospital B</td>
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<td>682.6</td>
<td>CELLULITIS/ABSCESS LEG</td>
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<td>999999999</td>
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<td>101010101</td>
<td>1234567</td>
<td>Hospital B</td>
<td>2008-08-25</td>
<td>733.42</td>
<td>ASEPSTIC NECROSIS HEAD &amp; NECK FEMUR</td>
<td>0-30 Days</td>
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<tr>
<td>121212121</td>
<td>1234567</td>
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<td>682.6</td>
<td>CELLULITIS/ABSCESS LEG</td>
<td>No ReAdmit</td>
<td></td>
</tr>
</tbody>
</table>

- **Less than 30 Days Since Last Admission**
- **Total Hip Replacement**
- **Not readmitted as of 2008Q3**
- **Not deceased**

DFWHC ERF 2009
Patient Safety & Quality Committee

Regionally-based Collaboration
Patient Safety & Quality Committee

- The Foundation’s Patient Safety & Quality Committee (PSQC) was founded with the purpose of improving the health care of the communities served through the effective use of healthcare data.

- The PSQC is comprised of 13 professionals with the following expertise:
  - Quality Improvement
  - Patient Safety
  - Infection Control
  - Data Analysis
  - Clinicians
  - Pharmacy

- Committee membership is by invitation only and members serve staggered two year terms.
PSQC history with analyzing AHRQ Quality Indicators

- **2007**: Focused on getting acquainted with the quality indicators
  - Various ways to look at the information (tables, charts, red light/green light, etc.)
  - Regional trends in AHRQ IQI’s and AHRQ PSI’s

- **2008 and 2009**: Focused on examining specific indicators at the hospital level and sharing lessons learned
Committee’s general process for working with CMS and AHRQ QIs

- Review annual and quarterly quality indicator data
- Decide on a process for discussing and sharing information in terms of quality improvement considering:
  - Trends and variation in the data
  - Relevant guidelines or policy implications associated with that indicator or the larger disease state/process
Example 1: AMI Mortality (AHRQ IQI #15)

Number of Deaths per 100 Discharges with a Principal Diagnosis Code of AMI

Risk Adjusted Rate

UCL=10.96
Avg=9.14
LCL=7.32

DFWHC ERF 2009
2000 - 2008
Example 1: AMI Mortality (AHRQ IQI #15)

- Based on positive regional trends, focused on contacting a select subset of hospitals for interview
- Goal was to determine if indicator performance was associated with the implementation of any specific process, protocols, etc.
- Committee collectively identified set of relevant questions
- Two volunteers interviewed six selected facilities and subsequently shared results with the larger group
Example 1: AMI Mortality (AHRQ IQI #15)

Themes shared as result of interviews:

- Clear focus on door to balloon time
  - Early notification by Emergency Medical Services (EMS) of the cardiac team
  - Use of standardized protocols and ED algorithms
- Presence of a dedicated team tracking and monitoring the acute myocardial infarction (AMI) patient
- Monitoring emphasis on the AMI portion of the core measure set (not the IQI)
Example 2: Post-Op DVT/PE (AHRQ PSI #12)

Cases of DVT or PE per 1,000 Surgical Discharges with an Operating Room Procedure.

- Avg = 10.16
- UCL = 12.08
- LCL = 8.24

Risk Adjusted Rate

DFWHC ERF 2009
Example 2: Post-Op DVT/PE (AHRQ PSI #12)

- Based on the indicator’s negative trends for the region and the majority of hospitals, we decided to use a multi-pronged approach for engaging hospitals on this issue.
  - Kicked off activities with an educational forum in late March 2009.
    - National content experts on deep vein thrombosis (DVT) awareness and changes to venous thromboembolism (VTE) quality measures and reimbursement policies.
    - Local panel discussion involving hospitals and home care
    - Demonstration to audience of the QI data and the analysis tools available to assist them as they work on this issue.
Example 2: Post-Op DVT/PE (AHRQ PSI #12)

- Launched a survey in mid-April to assess for themes regarding the region’s approach to VTE prophylaxis
  - Different approach than the AMI example
    - Made survey available to all interested hospitals
    - Used a structured online survey based on detailed literature review and validation by content experts
  - After completing analysis, will communicate results via multiple venues (committee meetings, forums, newsletters)

- Pursuing resources to conduct a detailed analysis of the clinical and financial outcomes of hospitals with comprehensive VTE risk assessment programs
Important Points

- AHRQ QI’s not necessarily widely understood or heavily monitored by hospitals

- There is no set way to engage hospitals in using the quality indicators as part of quality improvement activities

- Be flexible
Contacts

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469-648-5034

Ben Jacob, MPH  
bjacobs@dfwhc.org  
469-648-5031
Questions

To ask questions of our speakers, please:

- At any time, post your questions in the Q&A box on the right-hand side of your screen and press “send” to “all panelists”

  OR

- Click the “raise your hand” button to be unmuted and introduced to verbally ask a question
Agenda

- Welcome and Introduction
- Quality Improvement Overview
- Questions and Answers
- Dallas-Fort Worth Hospital Council Example
- Questions and Answers
- Pacific Business Group on Health Example
- Questions and Discussion
California Quality Collaborative (CQC)

Multi-stakeholder collaborative (plans, purchasers, providers and partners) staffed by Pacific Business Group on Health (PBGH) to accelerate measurable improvement
Outline

• Get oriented
• Why do QI?
• How we do QI: Some case studies
  What we gained
  What we learned
• Overall program participation and funding
<table>
<thead>
<tr>
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<th>Physician Group</th>
<th>Physician</th>
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<td>1.</td>
<td>Collect Standardized Data</td>
<td>CA Hospital Assessment and Reporting Task Force</td>
<td>PBGH</td>
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<td>Publicly Report</td>
<td>6 HMO Insurance Plans</td>
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<td></td>
<td><a href="http://www.calhospitalcompare.org">www.calhospitalcompare.org</a></td>
<td><a href="http://www.opa.ca.gov">www.opa.ca.gov</a></td>
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<tr>
<td></td>
<td>Began 2007</td>
<td>Began 2004</td>
<td>200 doctor groups</td>
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<td>4.</td>
<td>Improvement Support</td>
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### Medical Group Ratings At-a-Glance

#### Alameda

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### Meeting National Standards of Care

We compared each medical group’s patient records to a set of national standards for quality of care:

- Asthma Medicine
- Breast Cancer Screening
- Colorectal Cancer Screening
- Childhood Immunizations
- Chlamydia Screening
- Testing Cholesterol for Heart Patients
- Controlling Cholesterol for Heart Patients
- Testing Cholesterol for Diabetes Patients
- Controlling Cholesterol for Diabetes Patients
- Testing Blood Sugar for Diabetes Patients
- Controlling Blood Sugar for Diabetes Patients
- Testing Kidney Function for Diabetes Patients
- Treating Children with Urocare
Publicly Reported Measures

Clinical Quality
• Mostly HEDIS-based measures on preventive and chronic care

Patient Experience
• Collected through common statewide CAHPS-like survey

Investment and Adoption of IT
• Audited self-report

Resource Use
• Utilization (ED use, generic RX, readmissions), testing total cost of care and episode-based metrics

www.iha.org
Why Do QI?

• Changes the political dynamic
  – Walk the Improvement Talk: Builds trust with those in public report and creates more support from those sponsoring reporting (plans, purchasers)

• Results: 1+1 = 3
  – Cases where reporting plus QI get better results than either alone

• It’s fun and can be cheap
CQC Offerings 2008 - 2009

1. Implementation Collaboratives – 12 month programs for Improvement Teams
   1. Improving Patient Satisfaction Scores
   2. Improving Clinical Metrics
   3. Improving Efficiency/Total Cost

2. Regional Learning Networks – Free
   • Quarterly half-day sessions in local areas

3. Learning Exchanges - Free
   • One-day conferences on specific topics

4. One-day Skill Building Sessions – Minimal fee
   • Engaging Physicians in Change
   • ABCs of QI
   • Data Analysis and Project Management
   • Leadership Development
Improvement Support Options:

“One and Done”
1. Encourage Exchange of Effective Practices Across Organizations
   – One-day conferences, teleconferences
2. Document Better Practices
   – Catalogue most effective strategies and tools

On-going or Time Limited Programs
3. Build Learning Networks
   – Quarterly meetings for peers
4. Provide Implementation Support
   – Year-long training and coaching
Encouraging Peer-to-Peer Learning for “One and Done”

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<th>Traditional Conference</th>
<th>Encouraging Exchange of Effective Practices</th>
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<tbody>
<tr>
<td>Speakers</td>
<td>Famous individuals</td>
<td>Highest local performers, or those who are most improved</td>
</tr>
<tr>
<td>Agenda design</td>
<td>Fill time with good speakers</td>
<td>Plan 50% of time for speakers. 50% facilitated discussion/Q&amp;A.</td>
</tr>
<tr>
<td>Audience role</td>
<td>Listens and takes notes</td>
<td>Actively solicit other good ideas from audience, capture for all</td>
</tr>
<tr>
<td>Materials</td>
<td>Presentations</td>
<td>Ideas and tool summary</td>
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Case: Improving care in small and medium physician groups

www.calquality.org/documents/LAOC_Dec2_Agenda_final.doc
Build Learning Network Case: Inland Empire

- First meeting April 2007 included regional results (Lowest in the State)
- Quarterly on-sites, monthly teleconferences, newsletter
- 3-4 hour meetings following local provider association meeting on participant-driven improvement topics – most presenters local
- CQC facilitated planning group of providers, plans and others
- Resources: <.2 FTE plus meeting expenses
What Happened

• 23 out of 45 physician groups in the area participated over 12 months (35 – 60 people at quarterly on-site meetings)

• Publicly reported clinical results for participating organizations improve more than non-participants

• Other organizations in region joined
  – Local foundation, community groups, public hospitals, community clinics, etc.

• Reported and reporters very happy
Some Useful Learning Network Techniques

• Start with a launch conference
• Quarterly meetings 3-4 hours (lunch!)
• Every organization talks – go round at early meetings
• 3 brief presentations from network “members” to start discussion. No more than 50% presentation. “Tips” sent via newsletter.
• Blog newsletter http://inlandquality.wordpress.com
• Separate CEO dinner session
• Separate QI skills training
• Annual community conference draws new individuals and new organizations
Inland Quality Collaborative 2009 - Session 1: Community Resources & Physician Group Approaches to Effective Diabetes Care
May 18, 2009

This session, held May 13, 2009, was the kick-off of cycle 3 of the Inland Quality Collaborative addressing Community Resources and Provider Group Approaches to Effective Diabetes Care bringing together 17 physician organizations and health plans. We invited Nina Delgado of the Riverside Community Health Foundation and Roger Chen of the California Diabetes Program to share diabetes resources and provider/staff tools in the region, as well as information about current local initiatives and how provider groups can partner these efforts. We also invited local groups who are leading the way in diabetes care to share their programs and successful approaches – thank you to Dale Venaas, RN of Riverside Medical Clinic and Oleta Cook, RN and Teresa Hodgkins, Pharm.D of Desert Oasis Health Care for your great work and wisdom!

Click on the links below to view session materials. To save, right click on the link and select “Save Target As”

Session 1 Agenda – May 13, 2009
Provide Implementation Support
Case: Patient Experience

Summary: CQC Patient Experience Collaborative 2006 - 2007
Relative Change from 2007 - 2008

<table>
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<tr>
<th>P4P Domain</th>
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<th>CQC Pt. Exp. Collab Participants</th>
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<tr>
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Participants: Affinity Medical Group, Greater Newport Physicians
John Muir Health Network, Monarch Healthcare
Some Tips for Facilitating Peer-to-Peer Learning…

1. Content must be built around “self-identified peers” (regional focus, job type)
2. If possible, attach to existing meeting/organization (e.g., Hospital Association)
3. Use multi-stakeholder planning committee to design content, including “customers”
4. Learning vs. Teaching: Limit outside expert presentations, unless invited by attendees
   • Focus on showcasing best practices within peers
5. Audience wants to hear “How” from implementers themselves
Engagement in Change
Funding
$1.2 Million or $.03/Resident
Questions

To ask questions of our speakers, please:

- At any time, post your questions in the Q&A box on the right-hand side of your screen and press “send” to “all panelists”

  OR

- Click the “raise your hand” button to be unmuted and introduced to verbally ask a question
Next Web Forum

Question and Answer Web Forum

August 12, 2009, at 1:00 p.m. ET

John Bott, Center for Delivery, Organization, and Markets, AHRQ
Mamatha Pancholi, Center for Delivery, Organization, and Markets, AHRQ
Jeff Geppert, Battelle Memorial Institute (QI Developer)

You are welcome to invite others from your organization
For More Information

- QI Learning Institute Web Forum: https://ahrqqili.webexone.com/

  Login Name: First letter of first name followed by last name; capitalize first two letters (Example: JBott).

  If you forgot your password, enter your Login Name and press “Forgot your password?” and Webex will e-mail you a temporary password.

- QI Learning Institute E-Mail: QualityIndicatorsLearning@ahrq.hhs.gov

- QI Web Site: http://www.qualityindicators.ahrq.gov/

- QI Support E-Mail: support@qualityindicators.ahrq.gov
QILI Evaluation

Please fill out the evaluation form that will pop up on your screen after you leave the Web conference.

- The first two questions are about today’s Web conference.
- The remaining questions are about the QI Learning Institute in general.

We will incorporate all your feedback into the next contract, which we anticipate to be a similar learning network that will provide education and training on how to use MONAHRQ (previously named EQUIPS) for reporting initiatives. All current QILI members will be invited to join this new project.

We appreciate your feedback. Thank you for your participation!

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Today’s Learning Objectives

- Raise awareness of the opportunity to work on quality improvement with hospitals that appear in your public report
- Understand hospitals’ capacities to engage in quality improvement related to areas measured in your report
- Once a public report card is in place, understand strategies used by others to foster the spread of best practices among providers
- Learn from case examples the cost/benefit associated with strategies for facilitating peer-to-peer learning