GOOD GOVERNANCE CASE STUDY

An Online Series by **The Governance Institute®**

Health First Prepares for the Future Healthcare Business Model

(Part Two)

By Elaine Zablocki, *Staff Writer, The Governance Institute*

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Health First Prepares for the Future Healthcare Business Model

(Part Two)

Organization Profiled

Health First, Rockledge, Florida

Steven P. Johnson, President and CEO
James Shaw, Chair, Health First Board of Trustees
Drew Rector, Executive Vice President and Chief Strategy Officer
Edye Cleary, RN, Ph.D., Senior Vice President and Chief Quality Officer

Organization Profile

Health First is a not-for-profit, integrated delivery network serving Brevard County, Florida. Formed in 1995 when Holmes Regional Medical Center merged with Cape Canaveral Hospital to form Health First, its current statistics include:

- 40,000 inpatient visits
- 155,000 emergency department visits
- 3,400 babies delivered
- 117,000 patients cared for through Health First Medical Group

The Health First Integrated Delivery Network includes:

- Holmes Regional Medical Center (514 beds, Melbourne, FL)
- Cape Canaveral Hospital (150 beds, Cape Canaveral, FL)
- Palm Bay Hospital (152 beds, Palm Bay, FL)
- Viera Hospital (84 beds, Viera, FL)
- 25 Health First outpatient sites

Health First Health Plans, established in 1996, serves more than 62,000 members in Brevard and Indian River counties. The system also includes Health First Medical Group, an integrated network of more than 300 multi-specialty physicians and mid-level providers.

Outpatient services include:

- Fitness centers
- Home care
- Hospice
- Medical equipment
- Medical rehabilitation
- Urgent care

Statement of Interest

During the past two-and-a-half years, Health First has experienced major changes. Four independent hospitals started to act like a unified organization. Physicians started to receive scorecards on their quality and safety, cost-effectiveness, and patient satisfaction. Half of the system board members were persuaded to make room for new people with different skills and fresh ideas.

After long discussions (and 15 different drafts), the Health First Board of Trustees defined its primary purpose as "improving the health and wellness of our community while striving to provide locally the broadest/deepest scope of services that are sustainable in the long term." In support of that purpose, the system is developing an integrated network that will offer the full continuum of care to its patients.

In this case study, we will examine some of the factors that make Health First a leader in preparing for our future system of healthcare. Part One covered the effects of having a health plan within the system, incentivizing teamwork, partnering with physicians, and the strategic context for healthcare. Part Two will look at board reorganization, quality measurement, and the benefits of defining an organization's purpose.

Restructuring the Health First Board

You can have too much of a good thing, as Steve Johnson discovered when he took the reins of Health First, an integrated health system in east central Florida. In September 2011, when Johnson became Health First's CEO, he found not one or two, but 16 independent boards in place.

Health First had been growing since its 1995 birth from the merger of Holmes Regional Medical Center and Cape Canaveral Hospital. As the system grew, each new venture would have its own board. Although a system board existed, it acted primarily as a holding company board and not as the principal governing board for an integrated enterprise.

Johnson and system Board Chair James Shaw realized that a more integrated approach with a centralized governing board was critically important. An engineer by profession and a former division vice president of a large defense firm, Shaw was attuned to thinking about structure, systems, processes, and tools.

"When you have 16 different boards, you have a very clumsy structure, slow to make decisions," said Shaw, who since 1998 had served on various Health First boards and had also chaired the finance and strategy committees of the system board. "The board was not systems-focused, since each board focused on its part of the entity and not on how the entire organization operates as a whole. We needed to change."

Shaw and several key board members took on the task of reducing the number of boards and aligning those that remained. Flattening the board structure involved a fair amount of legal fine-tuning. The hospital boards were consolidated into the full system board. High-level physician and health plan issues are now handled at the system board level, while the physician group and health plan also have operational boards.

"There were a number of bylaw changes, but by far the most difficult challenge was making changes in the board membership," Shaw said. "We had great people on the board, but it was all based on geography. We had people with associations going back 20 to 30 years, and they came to the Health First board through the individual hospital boards. There were no term limits, and there was nothing driving change at the board level. Our board didn't have the skill sets required to become a value-based delivery network, and handle the sort of changes we are seeing in healthcare."

Shaw encouraged fellow board members to consider building board relevance by inviting new board members with new ideas.

He also discussed the actions needed to breathe new life into the board, including combining committees and organizing board education seminars. "Everyone agreed," he recalled. "We passed a resolution saying the first thing we were going to do is to restructure the board based on seeking the specific skills we need."

Eight members left the 15-member board, and Health First held a farewell dinner to acknowledge the contributions these long-term members had made. "When you start rotating board members, there's a lot of emotion involved," Shaw said. "That was the hardest part. These are the people who started Health First, who had the foresight to develop a health plan and to found a medical group. These are the people who created all these great assets. We owe them a great deal."

Shaw and other board members took on the task of transitioning the board from a management board focused on the minutia of operations to a governing board dedicated to mission and purpose. "I don't want to be managed, but I strongly desire to be governed," said Johnson.

A number of board committees were combined. The most important change was combining the nominating committee with governance. "Now we have one committee to look at term limits, succession planning, needed skill sets, and a formal education program, all as part of one process," said Shaw. "Now we are constantly in the mode of reviewing potential candidates and increasing the skill sets on the board."

Another important aspect of restructuring was a significant increase in highly focused board education. Health First depends on third-party interactive e-learning courses to support board members in their self-study of healthcare issues that include governance, finance, quality, and physician relations. Some board members are taking it to the next level by pursuing certification in various areas.

Each spring, the board holds a day-and-a-half educational retreat. Rather than going off-site, the retreat is held at corporate headquarters, in the boardroom. "We don't go off-site because we are facing a very tight budget," Shaw said. "We have to get Medicare to a breakeven level, and for us that means taking $125 million out of our cost structure. We intend to do this by being more effective and more efficient through continuous quality

improvement and Lean design. We have to walk the walk. We can't take the board to a luxurious setting at the same time we're asking our associates to streamline costs and make our processes more efficient."

The new board structure has positioned Health First to better meet the challenges of healthcare today. "They know the data, they know the market, they ask hard questions, they push the heck out of us," said Johnson. "Iron sharpens iron."

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>
> *—James Shaw, Board Chair*

Focusing the Board on Positive Change

Every quarter, Johnson makes a presentation at the board meeting he calls, "What's Going Well?" The topic ranges from HCAHPS scores to metrics of quality improvements compared to organizational goals. Or it might be a report on areas where integrated activities between physicians and the administration are functioning particularly smoothly.

"We think it's important to formally schedule time for 'What's Going Well?' on the board agenda," said Shaw. "Otherwise it's so easy to overlook positive improvements. Generally the board tends to focus on problems and what needs to be done next."

"We have to keep making changes, driving the process of continuous improvement," he added. "This means people really need to know that you appreciate and recognize their efforts that led to these achievements. We stop and make the time to do that."

For its part, the board makes a strong effort to communicate information throughout the entire organization. "Communications and transparency are critical," Shaw said. "At the board level, transparency is essential, through communication to Health First associates and also the community as a whole. We are responsible for managing an important community asset, so people need to understand what we are doing and why we are doing it."

Health First Board Reflects on Organizational Purpose

Patrick Lencioni's book, *The Advantage: Why Organizational Health Trumps Everything Else in Business*,[1] became the focus of several months' discussion at the top levels of Health First. Board members and top managers were all reading it. Over time the process led to significant changes in the way the board makes decisions.

Lencioni challenges organizations to think clearly about their purpose, not in vague generalities but in tangible, specific terms. The board asked itself questions such as:

- Why do we exist? What are our aspirations?
- How do we behave?
- What do we do (an explicit description)?
- How will we succeed?

Those questions served as the framework for a discussion focused on defining Health First's purpose. The purpose statement went through 15 different drafts. In the end, the board concluded: "Health First's primary focus is on improving the health and wellness of our community while striving to provide locally the broadest/deepest scope of services that are sustainable in the long term." In light of that primary purpose, the board agreed that "all options that further the achievement of our primary purpose should be considered."

Once the board defined Health First's purpose, it found many issues could be clarified within that context. For example, when several board members, concerned that efficiency could lead to job elimination, expressed their desire to maintain employment levels in the community, there was a clear response. "When there's a conflict between enhancing employment in the county, versus advancing our primary goal, which should prevail?" asked Johnson.

With a clearly defined purpose, the question was easy to answer. The primary purpose takes precedence, even over worthwhile goals such as maintaining employment levels. Eventually a pattern emerged, as board members began to routinely look at questions in terms of the organization's primary purpose.

The purpose statement also clarifies expectations for senior management. "In the end, we had a very clear statement about what our purpose was and what our purpose was not," Johnson recalled. "Then the board governs us by holding us accountable to moving along the roadmap we have developed and it has approved."

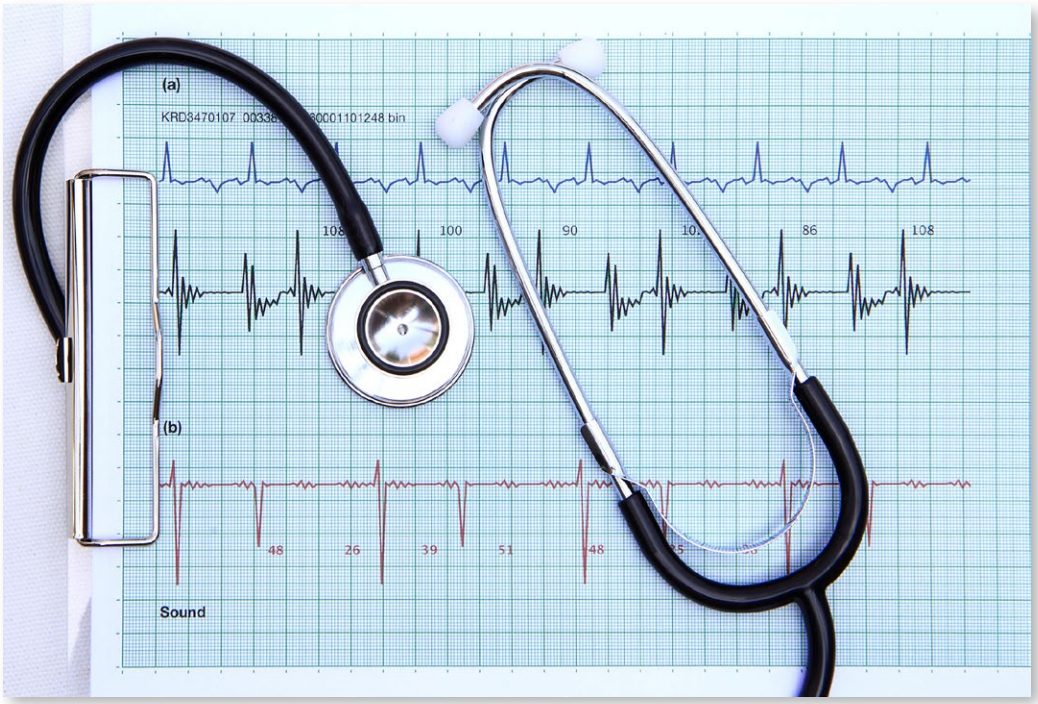
Once the board achieved clarity over the purpose statement, then it could define a specific roadmap for outcomes expected

1 Jossey-Bass, 2012.

in years ahead, while realizing that current plans extrapolate from current situations and retooling may be needed in the future.

With the roadmap in place, the board then turns to the CEO and his team to accomplish defined goals. The board annually conducts a formal review of management performance based on the pre-defined desired objectives for that particular year. In turn, the management team then reviews the board's performance. "We give them feedback on how well they governed us," Johnson said.

The board's purpose statement has been integrated with the Health First 2020 strategic plan, in a one-page graphic that summarizes the organization's strategy and approach in a few words. This internal document serves to spark discussions within the organization. "This sort of communication is critical at this juncture, because so many changes are taking place," explained Shaw. "People become nervous when they see so much change. We use Health First 2020 to create a context, to start a conversation so people understand why these changes are happening and what the impact will be."



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>
> *—James Shaw, Board Chair*

Case Management in an Integrated System

When Health First originally embarked on the road to integrated care, a variety of staff positions were responsible for managing the inpatient care process. Case managers, case coordinators, social workers, and utilization nurses were all part of the process, as were representatives from Project Red, which is designed to reduce congestive heart failure readmissions by focusing on discharging patients to appropriate settings after hospitalization.

"These various people were not part of a unified model," said Edye Cleary, RN, Ph.D. (candidate), Senior Vice President and Chief Quality Officer. "They were each responsible for their own separate role. Now we are moving to a centralized model, where we are taking those same resources and redeploying them in a more efficient way. The patient now encounters a single care coordinator throughout their hospitalization."

This major change has added a wider range of responsibilities to care coordinators. "They have a smaller case load, but they do everything from soup to nuts," added Cleary.

Coordination begins from the time the patient sets foot in the hospital and is assigned the status of inpatient or observation. "The coordinator gets in touch with the patient's payer to clarify why they're in the hospital and how long they are expected to stay," said Cleary. "They guide the patients throughout the hospitalization to ensure patients receive the most appropriate level of care."

Coordinators also offer disease management education for patients with long-term conditions such as congestive heart failure or heart attack, and they explore and recommend post-hospitalization services the patient may need. "The care coordinators help the patient navigate through this complex system, not only in the hospital, but also as they transition out into the community," said Cleary.

Under this new model, case managers are primarily registered nurses trained in disease management. However, Health First also relies on social workers for targeted needs such as crisis intervention, guardianship issues, or a very complex discharge plan.

To prepare the RNs for their new range of responsibilities, Health First administered a 90-day training program that included didactic classroom education and experiential learning, plus initial practical experience with a mentor or preceptor. The Health First Center for Learning developed a curriculum that explained the goals and structure of the new blended model. In addition, staff from InterQual, which provides the gold standard in evidence-based clinical decision support, led classes on the standards used by Medicare for determination of medical necessity for hospitalization.

"We also worked with our chief medical officer and our physician champions to review evidence-based care for high-risk,

high-volume populations who have a significant likelihood of readmissions, such as patients suffering from congestive heart failure or chronic obstruction pulmonary disease," Cleary recalled. "We had highly skilled licensed clinical social workers offering training on how to access community resources available for these patients."

At one point, Health First had experimented with merging hospital and health plan case managers, but the experiment proved to be too much, too fast. "The case management component within the health plan was used to manage utilization of providers," said Johnson. "These case managers were used to saying 'no, that's the wrong level of care.' The case managers within the delivery component were used to saying 'hey, this patient does need this care. I want to appeal the denial because they are not ready to go home.' They were speaking two different languages."

At present, the health plan continues to review the status of members and approve or deny specific services. The hospital case manager is responsible for the patient throughout the inpatient stay; then the patient is transitioned to the health plan case manager for continuing care. Health plan patients with certain chronic conditions may be able to access disease management and other community services that are not available to non-members.

Health First Health Plan patients can often access preventive services that reduce readmissions. For example, plan patients with chronic heart failure and sudden weight gain receive a home visit from a nurse. "Not all payers cover those services," said Cleary. "Our vision for the future, with an integrated delivery system, is to be able to offer that same level of service to all our patients over the next two years. Meanwhile, in the short term, we try to work with other payers to mimic some of those services as far as we can. In some situations, we may ask our home healthcare services to do a home visit for a particular patient. We have no one to bill, but we feel that for the safety of the patient, this is the appropriate thing to do."

The hospital also uses follow-up phone calls and ongoing diet and disease management education to create a bridge for patients until they develop a link with their next provider.

> "Now we are moving to a centralized model, where we are taking the same resources and redeploying them in a more efficient way. The patient now encounters a single care coordinator throughout their hospitalization. [The care coordinators] have a smaller case load, but they do everything from soup to nuts."
>
> *—Edye Cleary, RN, Ph.D., Senior Vice President & Chief Quality Officer*

Reporting on Quality

Every Health First board meeting starts with a report on quality and safety. Over the past two years, the organization has developed tools to look closely at a wide range of quality measures. Quality dashboards start at the board level, with broad composite measures. Then they drill down to the entity level and the department level, and go through each domain of quality in detail (see appendices for sample dashboards).

For example, the board needs to monitor the rate of hospital-acquired conditions. It sees a composite measure that includes about 11 indicators. That composite measure summarizes data on infections, falls, pressure ulcers, and similar problems. The board monitors readmissions within 30 days of discharge for all causes, another very broad measure.

Each hospital sees these "top level" numbers, and can use them to compare itself to other hospitals in the system. Each department within each hospital receives a much more detailed analysis. Regarding pressure ulcers, falls, and the like, each department works through a process to analyze why this happened and how to prevent it from happening again, whenever possible. When looking at readmissions, the neurosurgical unit for example would look closely to see how many stroke patients are being readmitted, and review their cases to see what could have been done differently. This same process occurs in each of the various business units throughout the integrated delivery network. For instance, the Health First Medical Group as a whole monitors "primary care contact within seven days of hospital discharge." In turn, each of the offices within the group track their individual compliance to this measure.

Key details and goals related to quality measures are posted on bulletin boards throughout the system. "As a hospital example, each staff member can see how they contribute to the fall rate or the readmission rate on their unit," Cleary said. "We're all working towards the same goals."

In addition to currently monitored measures, Health First keeps tabs on measures it suspects will be monitored in future years. "We're looking at process measures associated with venous thromboembolism [VTE], because we know this is a developing measure, and will eventually replace some of the historic process measures such as congestive heart failure or pneumonia care," Cleary said. Instituting evidence-based practices, processes, and tools have improved Health First's performance with the VTE care bundle from a baseline rate below the 25th percentile in 2013

to sustained rates at or above the 90th percentile. "Additionally, we suspect that many of the hospital-acquired conditions may be included in the value-based purchasing outcome measures in the near future," said Cleary.

The rate of early elective deliveries is another matter for concern. "We are relying on increased patient engagement around this issue, explaining to parents the possible risks for the infant with early deliveries," Cleary said. "We're aware that sometimes the timing of elective deliveries are scheduled because they are convenient for the physician. Right now, whenever an elective delivery is scheduled before 39 weeks, we have a hard stop in place, requiring a review to evaluate whether there are medical reasons." As a result of this process, Health First has reduced its early elective delivery rate from over 15 percent to less than the national benchmark of 3 percent, and with the last nine consecutive months at 0 percent across the system.

National benchmarks are another valuable aspect of the quality dashboards. "We use various sources to identify top decile performance levels, and that's really what our target is," Cleary said. While the quality dashboards have only been in place since early 2013, they are already having an effect. "Setting top decile targets really reengaged everyone," she reported. It is important to note that this goal setting transcends all four divisions—hospital, outpatient and wellness, medical group, and health plan—in order to achieve the Health First 2020 goal of achieving outcomes within the top 10 percent nationally. "Quite a few people said, 'We thought we were doing well, but now we see how we compare to everybody else, and we do have a long way to go.'"

Moving Fast and Expecting Success

The goal of a complete continuum of care that emphasizes prevention as well as procedures promises improved health for entire populations. Achieving this goal will require truly major changes that impact everyone from bedside nurses and community-based physicians to patients and their loved ones.

This degree of change can be a challenge for physicians and long-term associates who are now asked to do things in new ways. It takes time to absorb new information. It takes repeated effort to unlearn old habits.

At the same time, Johnson believes that expectations in large part create results. One aspect of propagating positive changes is having confidence in people's ability to learn new skills, and giving them the time and training they need to be successful. "While it is true there is a limit to the amount of change people can absorb within a given timeframe, in my experience people also rise to the expectations you create, as long as the process is filled with the expectation of and celebration of success," he said.

> "If zero is an old-style hospital company, organized in silos, and 100 is a fully integrated delivery network, we're probably at 65. We have made enormous progress, but we still have more to do. We need to develop processes that will embrace both our employed physicians and our aligned physicians with incentives to steer them in the direction of wellness, quality, and efficiency."
>
> *— Steven P. Johnson, President & CEO*

Challenges Ahead

Although they have already initiated dramatic changes, Health First leaders continue planning for the future. "If zero is an old-style hospital company, organized in silos, not advancing a modern agency, and 100 is a fully integrated delivery network operating even beyond exemplars such as Geisinger and Kaiser, we're probably at 65," Johnson said. "We have made enormous progress, but we still have more to do. We need to develop processes that will embrace both our employed physicians and our aligned physicians with incentives to steer them in the direction of wellness, quality, and efficiency."

Shaw noted that the biggest challenges Health First faces over the next two years will be clinical integration and continued work on the scale of the organization. "This is one reason it is particularly important to recognize and celebrate successful physician-led initiatives," he said. "They are the key to our future."

When Johnson worked at SSM Healthcare, his mentor Sister Mary Jean Ryan told him, "Steal shamelessly. When you see great ideas, steal them." Today, he puts that into practice. "We have many innovative programs, but everything we're doing is something we've heard about from another organization," he said. "The converse of Sister Mary Jean's motto, which is equally true, is to give freely. We steal ideas and we share ideas, because we want healthcare to get better for everybody."

Appendix 1: Health First Dashboard Action Plan

Health First Dashboard Action Plan
Palm Bay Hospital

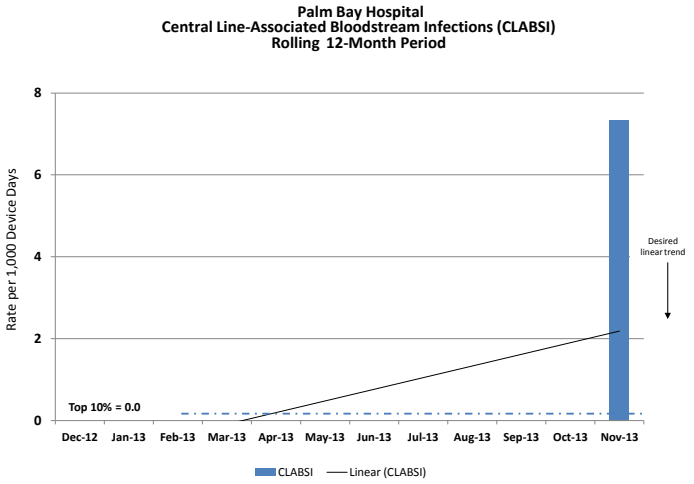
Dashboard	Measure	Month of Reporting
BOT Quality Dashboard	HAC O/E Ratio: CLABSI	January 2014
Executive Sponsor	**Action Plan Leader**	**Target Date**
Judy Gizinski, COO	Carolyn Powers	March 2014
Action Plan – Goal		
To ensure prevention of hospital-acquired conditions consistently below the expected rate		

Description of Action Plan:

Data timeframe: November 2013
HAC O/E Ratio: 2.4 **FYTD: 1.7**
CLABSI Rate: 7.4 = < 25th percentile FYTD: 3.1 = < 25th percentile

Analysis:
During the month of November, there were three (3) CLASBI. Prior to these cases, there was a trend of 44 consecutive months without a catheter-associated bloodstream infection. These cases underwent an intensive review for analysis of possible factors/trends including evidence-based care, type of catheter, flora, patient care units, physicians, and staff. No variances were identified and no common factors found in these three (3) particular cases. However, daily Infection Control review of central line utilization and bundle compliance has found occasional loose dressings and unsecured catheters. These discrepancies have been immediately brought to the attention of unit leadership for correction.

Actions:
- Nursing leadership will conduct concurrent audits pertaining to bundle compliance; adverse findings will be corrected immediately and utilized for just-in-time education.
- Initiation of daily Chlorhexidine baths for ICU Central Line patients has been approved at PBH Medical QI on 1/8/2013; PBH team will implement this process within 30–45 days.
- Lean process review of Central Line insertion, care, maintenance, and discontinuation process scheduled to begin in January 2014.
- Infection Control will evaluate the cost-benefit of CHG Bath for all Central Line patients as well as disinfection caps; findings of these analyses will be presented to the Value Analysis Team and Infection Control Committee in February 2014.



Appendix 2: Quality/No Harm Dashboard

Health First Quality/No Harm Dashboard
Board of Trustees
Reporting Month: January 2014

QUALITY / NO HARM	SOURCE	PERIOD	FAV	CURRENT PERIOD RESULT	CURRENT PERIOD TARGET	CURRENT PERIOD VAR	FISCAL YEAR-TO-DATE RESULT	FISCAL YEAR-TO-DATE TARGET	FISCAL YEAR-TO-DATE TOP 10%	FISCAL YEAR-TO-DATE VAR
HOSPITAL PLATFORM										
AHRQ Patient Safety Composite (PSI-90) **	CRIMSON	Nov	↓	1.98	0.60	○	1.41	0.60	0.39	○
Hospital-Acquired Conditions - Composite (O/E Ratio)	CRIMSON	Nov	↓	0.99	1.0	●	0.86	1.0	< 1.0	●
Mortality Rate - Overall (O/E Ratio)	CRIMSON	Nov	↓	0.71	1.0	●	0.75	1.0	< 1.0	●
Hospital-Wide All-Cause Readmissions (O/E Ratio)	CRIMSON	Nov	↓	0.43	1.0	●	0.75	1.0	< 1.0	●
Medicare Spending Per Beneficiary **	CMS		↓	Awaiting CMS Data Refresh						
OUTPATIENT PLATFORM (HFHC-HF Home Care)										
HFHC Preventing Harm All-or-None Bundle	HH-GOLD	Nov	↑	86.3%	82.8%	●	82.5%	82.8%	90.8%	◑
HFHC Rehospitalization While Receiving Services	OASIS	Nov	↓	17.1%	16.0%	◑	15.1%	16.0%	< 13%	●
HFHC ED Use While Receiving Services (without readmit)	OASIS	Nov	↓	3.4%	10.0%	●	2.7%	10.0%	< 8%	●
MEDICAL GROUP										
Influenza Immunization for Patients Age > 60	PMS	Nov	↑	29.3%	65%	○	28.4%	65%		○
Primary Care Contact w/in 7 Days of Hospital Discharge	PMS	Nov	↑	13.1%	75%	○	10.1%	75%		○
HEALTH PLAN										
All-Cause Readmission Rate	MIDAS	Nov	↓	9.1%	11%	●	9.9%	11%		●

** = FY2016 VBP measures (performance period = CY2014); Top 10% values per published CMS VBP benchmarks (CMS-1599 10/2013)

CUSTOMER EXPERIENCE	SOURCE	PERIOD	FAV	CURRENT PERIOD RESULT	CURRENT PERIOD %TILE	CURRENT PERIOD TARGET	CURRENT PERIOD VAR	FISCAL YEAR-TO-DATE RESULT	FISCAL YEAR-TO-DATE %TILE	FISCAL YEAR-TO-DATE TARGET	FISCAL YEAR-TO-DATE TOP 10%	FISCAL YEAR-TO-DATE VAR
BY ENTITY												
Hospitals-Tertiary: Overall Rating of Hospital **	PG	Nov	↑	77%	76th	> 50th	●	66%	28th	> 50th	83.8%	◑
Hospitals-Community: Overall Rating of Hospital **	PG	Nov	↑	78%	81st	> 75th	●	80%	85th	> 75th	83.8%	●
Home Health: Overall Rating of Agency	PG	Nov	↑	93%	91st	> 50th	●	83%	23rd	> 50th	90%	○
Hospice: Overall Rating of Care as "Excellent"	NHPCO	Q3 2013	↑	92%		> 85%	●	85%		> 85%	85%	●
Medical Group: Overall Rating of Doctor	PG	Nov	↑	87%	62nd	> 75th	◑	86%	60th	> 75th	90%	◑
Health Plan: Overall Rating of Plan	HEDIS	CY2013	↑	2.65	75th	90th	◑	2.65	75th	90th	2.68	◑

Note: Data based on patient discharge or service date

Legend	○	◑	●
For Percentile Target > 50th	< 25th	≥ 25th to < 50th	≥ 50th
For Percentile Target > 75th	< 50th	≥ 50th to < 75th	≥ 75th
For Percentile Target > 90th	< 75th	≥ 75th to < 90th	≥ 90th
For Numerical Target	> 10% from target	Within 10% of target	Met target

Health First Quality/No Harm Dashboard - BOT

Holmes Regional Medical Center

Reporting Month: January 2014

				CURRENT PERIOD				FISCAL YEAR-TO-DATE				
SAFETY												
HOSPITAL-ACQUIRED HARM	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
CARE DELIVERY-RELATED HARM												
AHRQ Patient Safety Composite (PSI-90) **	CRIMSON	Nov	↓	2.6		0.6	○	1.9		0.6	0.39	○
Pressure Ulcer Rate - Stage III/IV	PORTAL	Nov	↓	0.3		0.3	●	0.3		0.3	0.17	●
Hospital-Acquired Conditions - Composite (O/E Ratio)	CRIMSON	Nov	↓	0.74		1.0	●	0.79		1.0	< 1.0	●
Fall Rate - Significant Harm	PORTAL	Nov	↓	0.0		0.6	●	0.0		0.6	< 0.6	●
Venous Thromboembolism (VTE) Rate	MIDAS	Nov	↓	1.1		0.8	○	1.0		0.8	0.6	○
INFECTION-RELATED HARM												
Catheter-Associated Urinary Tract Infection Rate **	NHSN	Nov	↓	0.8	< 75th	> 75th	◑	0.8	< 75th	> 75th	0.0	◑
Catheter-Associated Bloodstream Infection Rate **	NHSN	Nov	↓	0.8	< 50th	> 50th	◑	0.8	< 50th	> 50th	0.0	◑
Surgical Site Infection - Colon Surgery **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	1.3	< 90th	> 75th	0.0	●
Surgical Site Infection - Abd. Hysterectomy **	NHSN	Nov	↓	1.9	< 25th	> 50th	○	0.9	< 25th	> 50th	0.0	○
PROCEDURE-RELATED HARM												
Surgical Mortality w/ Complications (PSI-4)	CRIMSON	Nov	↓	0.0		110.25	●	66.7		110.25	< 100	●

CLINICAL CARE												
CORE MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
PROCESS MEASURES												
SCIP - All-or-None Bundle **	MIDAS	Nov	↑	97.8%	< 50th	> 50th	◑	98.2%	< 50th	> 50th	100%	◑
VTE - All-or-None Bundle	MIDAS	Nov	↑	97.4%	< 75th	> 50th	●	96.5%	< 75th	> 50th	100%	●
STK - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 75th	●	98.8%	< 75th	> 75th	100%	◑
PNE - Initial Antibx Selection **	MIDAS	Nov	↑	100%	> 90th	> 50th	●	97.4%	< 50th	> 50th	100%	◑
IMM - Immunization for Influenza ** (October-March)	MIDAS	Nov	↑	96.4%	< 50th	> 75th	○	94.2%	< 50th	> 75th	99.1%	○
OUTCOMES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
MORTALITY MEASURES												
Mortality Rate - Overall (O/E Ratio)	CRIMSON	Nov	↓	0.79		1.0	●	0.79		1.0	< 1.0	●
AMI - 30 Day Survival Rate **	MIDAS	Nov	↑	90.2%		84.8%	●	88.5%		84.8%	87.3%	●
CHF - 30 Day Survival Rate **	MIDAS	Nov	↑	98.6%		88.3%	●	99.3%		88.3%	90.8%	●
PNE - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		88.1%	●	100%		88.1%	90.7%	●
READMISSION MEASURES												
Hospital-Wide All-Cause Readmissions (O/E Ratio)	CRIMSON	Nov	↓	0.42		1.0	●	0.76		1.0	< 1.0	●

EFFICIENCY												
UTILIZATION MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
THROUGHPUT MEASURES												
ED-IP Median ED Arrival to ED Departure Time (min)	MIDAS	Nov	↓	256 min	< 90th	275 min	●	250 min	< 90th	275 min	177 min	●
COST REDUCTION / FINANCIAL MEASURES												
Medicare Spending Per Beneficiary **	CMS		↓	Awaiting CMS Data Refresh				Awaiting CMS Data Refresh				

** = FY2016 VBP measures (performance period = CY2014)

Note: Top 10% values per published CMS VBP benchmarks (CMS-1599 10/2013), CMS top 10% national rates & evidence-based benchmarks

Note: Baseline numerical targets based on national averages

Legend	○	◑	●
For Percentile Target > 50th	< 25th	≥ 25th to < 50th	≥ 50th
For Percentile Target > 75th	< 50th	≥ 50th to < 75th	≥ 75th
For Percentile Target > 90th	< 75th	≥ 75th to < 90th	≥ 90th
For Numerical Target	> 10% from target	Within 10% of target	Met target

Health First Quality/No Harm Dashboard - BOT
Cape Canaveral Hospital
Reporting Month: January 2014

				CURRENT PERIOD				FISCAL YEAR-TO-DATE				
SAFETY												
HOSPITAL-ACQUIRED HARM	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
CARE DELIVERY-RELATED HARM												
AHRQ Patient Safety Composite (PSI-90) **	CRIMSON	Nov	↓	0.6		0.6	●	0.3		0.6	0.39	●
Pressure Ulcer Rate - Stage III/IV	PORTAL	Nov	↓	0.0		0.3	●	0.0		0.3	0.17	●
Hospital-Acquired Conditions - Composite (O/E Ratio)	CRIMSON	Nov	↓	1.5		1.0	○	1.1		1.0	< 1.0	◑
Fall Rate - Significant Harm	PORTAL	Nov	↓	0.0		0.6	●	0.2		0.6	< 0.6	●
Venous Thromboembolism (VTE) Rate	MIDAS	Nov	↓	0.4		0.8	●	0.7		0.8	0.6	●
INFECTION-RELATED HARM												
Catheter-Associated Urinary Tract Infection Rate **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	0.8	< 75th	> 75th	0.0	◑
Catheter-Associated Bloodstream Infection Rate **	NHSN	Nov	↓	0.0	> 90th	> 50th	●	1.2	< 50th	> 50th	0.0	◑
Surgical Site Infection - Colon Surgery **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	0.0	> 90th	> 75th	0.0	●
Surgical Site Infection - Abd. Hysterectomy **	NHSN	Nov	↓	0.0	> 90th	> 50th	●	0.0	> 90th	> 50th	0.0	●
PROCEDURE-RELATED HARM												
Surgical Mortality w/ Complications (PSI-4)	CRIMSON	Nov	↓	0.0		110.25	●	0.0		110.25	< 100	●

CLINICAL CARE												
CORE MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
PROCESS MEASURES												
SCIP - All-or-None Bundle **	MIDAS	Nov	↑	100%	> 90th	> 75th	●	98.5%	< 50th	> 75th	100%	○
VTE - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 75th	●	98.9%	< 90th	> 75th	100%	●
STK - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 75th	●	100%	> 90th	> 75th	100%	●
PNE - Initial Antibx Selection **	MIDAS	Nov	↑	93.8%	< 25th	> 50th	○	96.2%	< 25th	> 50th	100%	○
IMM - Immunization for Influenza ** (October-March)	MIDAS	Nov	↑	100%	> 90th	> 90th	●	99.4%	< 90th	> 90th	99.1%	◑
OUTCOMES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
MORTALITY MEASURES												
Mortality Rate - Overall (O/E Ratio)	CRIMSON	Nov	↓	0.87		1.0	●	0.90		1.0	< 1.0	●
AMI - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		84.8%	●	96.8%		84.8%	87.3%	●
CHF - 30 Day Survival Rate **	MIDAS	Nov	↑	95.7%		88.3%	●	95.2%		88.3%	90.8%	●
PNE - 30 Day Survival Rate **	MIDAS	Nov	↑	92.0%		88.1%	●	94.3%		88.1%	90.7%	●
READMISSION MEASURES												
Hospital-Wide All-Cause Readmissions (O/E Ratio)	CRIMSON	Nov	↓	0.37		1.0	●	0.65		1.0	< 1.0	●

EFFICIENCY												
UTILIZATION MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
THROUGHPUT MEASURES												
ED-IP Median ED Arrival to ED Departure Time (min)	MIDAS	Nov	↓	239 min	< 90th	275 min	●	261 min	< 90th	275 min	177 min	●
COST REDUCTION / FINANCIAL MEASURES												
Medicare Spending Per Beneficiary **	CMS		↓	Awaiting CMS Data Refresh				Awaiting CMS Data Refresh				

** = FY2016 VBP measures (performance period = CY2014)
Note: Top 10% values per published CMS VBP benchmarks (CMS-1599 10/2013), CMS top 10% national rates & evidence-based benchmarks
Note: Baseline numerical targets based on national averages

Legend	○	◑	●
For Percentile Target > 50th	< 25th	≥ 25th to < 50th	≥ 50th
For Percentile Target > 75th	< 50th	≥ 50th to < 75th	≥ 75th
For Percentile Target > 90th	< 75th	≥ 75th to < 90th	≥ 90th
For Numerical Target	> 10% from target	Within 10% of target	Met target

Health First Quality/No Harm Dashboard - BOT

Palm Bay Hospital

Reporting Month: January 2014

				CURRENT PERIOD				FISCAL YEAR-TO-DATE				
SAFETY												
HOSPITAL-ACQUIRED HARM	SOURCE	PERIOD	FAV	RESULT	% TILE	TARGET	VAR	RESULT	% TILE	TARGET	TOP 10%	VAR
CARE DELIVERY-RELATED HARM												
AHRQ Patient Safety Composite (PSI-90) **	CRIMSON	Nov	↓	0.6		0.6	●	0.6		0.6	0.39	●
Pressure Ulcer Rate - Stage III/IV	PORTAL	Nov	↓	0.0		0.3	●	0.2		0.3	0.17	●
Hospital-Acquired Conditions - Composite (O/E Ratio)	CRIMSON	Nov	↓	2.4		1.0	○	1.7		1.0	< 1.0	○
Fall Rate - Significant Harm	PORTAL	Nov	↓	0.0		0.6	●	0.0		0.6	< 0.6	●
Venous Thromboembolism (VTE) Rate	MIDAS	Nov	↓	1.8		0.8	○	0.9		0.8	0.6	○
INFECTION-RELATED HARM												
Catheter-Associated Urinary Tract Infection Rate **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	0.0	> 90th	> 75th	0.0	●
Catheter-Associated Bloodstream Infection Rate **	NHSN	Nov	↓	7.4	< 25th	> 90th	○	3.1	< 25th	> 90th	0.0	○
Surgical Site Infection - Colon Surgery **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	0.0	> 90th	> 75th	0.0	●
Surgical Site Infection - Abd. Hysterectomy **	NHSN	Nov	↓	no cases				no cases				
PROCEDURE-RELATED HARM												
Surgical Mortality w/ Complications (PSI-4)	CRIMSON	Nov	↓	0.0		110.25	●	0.0		110.25	< 100	●

CLINICAL CARE												
CORE MEASURES	SOURCE	PERIOD	FAV	RESULT	% TILE	TARGET	VAR	RESULT	% TILE	TARGET	TOP 10%	VAR
PROCESS MEASURES												
SCIP - All-or-None Bundle **	MIDAS	Nov	↑	100%	> 90th	> 75th	●	100%	> 90th	> 75th	100%	●
VTE - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 50th	●	100%	> 90th	> 50th	100%	●
STK - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 50th	●	100%	> 90th	> 50th	100%	●
PNE - Initial Antibx Selection **	MIDAS	Nov	↑	100%	> 90th	> 90th	●	100%	> 90th	> 90th	100%	●
IMM - Immunization for Influenza ** (October-March)	MIDAS	Nov	↑	98.9%	< 90th	> 75th	●	98.3%	< 75th	> 75th	99.1%	◑
OUTCOMES	SOURCE	PERIOD	FAV	RESULT	% TILE	TARGET	VAR	RESULT	% TILE	TARGET	TOP 10%	VAR
MORTALITY MEASURES												
Mortality Rate - Overall (O/E Ratio)	CRIMSON	Nov	↓	0.41		1.0	●	0.53		1.0	< 1.0	●
AMI - 30 Day Survival Rate **	MIDAS	Nov	↑	83.3%		84.8%	◑	91.7%		84.8%	87.3%	●
CHF - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		88.3%	●	100%		88.3%	90.8%	●
PNE - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		88.1%	●	100%		88.1%	90.7%	●
READMISSION MEASURES												
Hospital-Wide All-Cause Readmissions (O/E Ratio)	CRIMSON	Nov	↓	0.49		1.0	●	0.86		1.0	< 1.0	●

EFFICIENCY												
UTILIZATION MEASURES	SOURCE	PERIOD	FAV	RESULT	% TILE	TARGET	VAR	RESULT	% TILE	TARGET	TOP 10%	VAR
THROUGHPUT MEASURES												
ED-IP Median ED Arrival to ED Departure Time (min)	MIDAS	Nov	↓	236 min	< 90th	275 min	●	230 min	< 90th	275 min	177 min	●
COST REDUCTION / FINANCIAL MEASURES												
Medicare Spending Per Beneficiary **	CMS		↓	Awaiting CMS Data Refresh				Awaiting CMS Data Refresh				

** = FY2016 VBP measures (performance period = CY2014)

Note: Top 10% values per published CMS VBP benchmarks (CMS-1599 10/2013), CMS top 10% national rates & evidence-based benchmarks

Note: Baseline numerical targets based on national averages

Legend	○	◑	●
For Percentile Target > 50th	< 25th	≥ 25th to < 50th	≥ 50th
For Percentile Target > 75th	< 50th	≥ 50th to < 75th	≥ 75th
For Percentile Target > 90th	< 75th	≥ 75th to < 90th	≥ 90th
For Numerical Target	> 10% from target	Within 10% of target	Met target

Health First Quality/No Harm Dashboard - BOT

Viera Hospital

Reporting Month: January 2014

				CURRENT PERIOD				FISCAL YEAR-TO-DATE				
SAFETY												
HOSPITAL-ACQUIRED HARM	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
CARE DELIVERY-RELATED HARM												
AHRQ Patient Safety Composite (PSI-90) **	CRIMSON	Nov	↓	1.0		0.6	○	1.3		0.6	0.39	○
Pressure Ulcer Rate - Stage III/IV	PORTAL	Nov	↓	0.0		0.3	●	0.0		0.3	0.17	●
Hospital-Acquired Conditions - Composite (O/E Ratio)	CRIMSON	Nov	↓	0.0		1.0	●	0.0		1.0	< 1.0	●
Fall Rate - Significant Harm	PORTAL	Nov	↓	0.0		0.6	●	0.0		0.6	< 0.6	●
Venous Thromboembolism (VTE) Rate	MIDAS	Nov	↓	0.0		0.8	●	0.9		0.8	0.6	○
INFECTION-RELATED HARM												
Catheter-Associated Urinary Tract Infection Rate **	NHSN	Nov	↓	0.0	> 90th	> 75th	●	0.0	> 90th	> 75th	0.0	●
Catheter-Associated Bloodstream Infection Rate **	NHSN	Nov	↓	0.0	> 90th	> 50th	●	0.0	>90th	> 50th	0.0	●
Surgical Site Infection - Colon Surgery **	NHSN	Nov	↓	no cases		> 75th		0.0	> 90th	> 75th	0.0	●
Surgical Site Infection - Abd. Hysterectomy **	NHSN	Nov	↓	0.0	> 90th	> 50th	●	0.0	> 90th	> 50th	0.0	●
PROCEDURE-RELATED HARM												
Surgical Mortality w/ Complications (PSI-4)	CRIMSON	Nov	↓	0.0		110.25	●	0.0		110.25	< 100	●

CLINICAL CARE												
CORE MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
PROCESS MEASURES												
SCIP - All-or-None Bundle **	MIDAS	Nov	↑	100%	> 90th	> 75th	●	98.2%	< 50th	> 75th	100%	○
VTE - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 75th	●	100%	> 90th	> 75th	100%	●
STK - All-or-None Bundle	MIDAS	Nov	↑	100%	> 90th	> 75th	●	100%	> 90th	> 75th	100%	●
PNE - Initial Antibx Selection **	MIDAS	Nov	↑	100%	> 90th	> 90th	●	100%	> 90th	> 90th	100%	●
IMM - Immunization for Influenza ** (October-March)	MIDAS	Nov	↑	100%	> 90th	> 90th	●	99.1%	< 90th	> 90th	99.1%	◑
OUTCOMES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
MORTALITY MEASURES												
Mortality Rate - Overall (O/E Ratio)	CRIMSON	Nov	↓	0.33		1.0	●	0.44		1.0	< 1.0	●
AMI - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		84.8%	●	100%		84.8%	87.3%	●
CHF - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		88.3%	●	100%		88.3%	90.8%	●
PNE - 30 Day Survival Rate **	MIDAS	Nov	↑	100%		88.1%	●	100%		88.1%	90.7%	●
READMISSION MEASURES												
Hospital-Wide All-Cause Readmissions (O/E Ratio)	CRIMSON	Nov	↓	0.48		1.0	●	0.71		1.0	< 1.0	●

EFFICIENCY												
UTILIZATION MEASURES	SOURCE	PERIOD	FAV	RESULT	%TILE	TARGET	VAR	RESULT	%TILE	TARGET	TOP 10%	VAR
THROUGHPUT MEASURES												
ED-IP Median ED Arrival to ED Departure Time (min)	MIDAS	Nov	↓	231 min	< 90th	275 min	●	230 min	< 90th	275 min	177 min	●
COST REDUCTION / FINANCIAL MEASURES												
Medicare Spending Per Beneficiary **	CMS		↓	Awaiting CMS Data Refresh				Awaiting CMS Data Refresh				

** = FY2016 VBP measures (performance period = CY2014)

Note: Top 10% values per published CMS VBP benchmarks (CMS-1599 10/2013), CMS top 10% national rates & evidence-based benchmarks

Note: Baseline numerical targets based on national averages

Legend	○	◑	●
For Percentile Target > 50th	< 25th	≥ 25th to < 50th	≥ 50th
For Percentile Target > 75th	< 50th	≥ 50th to < 75th	≥ 75th
For Percentile Target > 90th	< 75th	≥ 75th to < 90th	≥ 90th
For Numerical Target	> 10% from target	Within 10% of target	Met target