GOOD GOVERNANCE CASE STUDY

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

Quality Reporting Expands beyond Hospital Walls

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ORGANIZATION PROFILED:

BayCare Health System, Clearwater, FL
Bruce Flareau, M.D., Executive Vice President, Physician Affairs; President, BayCare Physician Partners
Charles DeShazer, M.D., Chief Quality Officer
Lisa Johnson, RN, B.S.N., Chief Nurse Executive

Statement of Interest

Visitors to the BayCare Health System home page will see a large button off to the left labeled "Quality: a Report to Our Communities." Clicking on that button provides access to a remarkable quality report card.[1]

These days, many hospitals and health systems are offering their patients increasing information about the quality of care they can expect when they enter the hospital. However, the BayCare quality report card is an outstanding example of detailed information. It offers outcome measures, in addition to process measures, and those measures are carefully selected to be meaningful. The BayCare report card presents this information in a format that highlights key points for people who want to understand their care, but who may not be sophisticated readers of statistical charts.

In addition to an exemplary presentation of hospital-based quality data, BayCare has embarked on a far-reaching effort to gather and share quality data about every aspect of the system, not just the events that take place within hospital walls. This case study provides a detailed review of BayCare's hospital-based quality report card, and then explores the organization's efforts to expand quality reporting beyond hospital walls, across the care continuum.

Organization Profile

BayCare Health System, formed in 1997, includes 10 not-for-profit hospitals with a total of 2,884 beds, as well as home health services, nursing homes, and other auxiliary services. The system serves Tampa Bay and the surrounding area in west-central Florida, with a population of about four million people. It is organized into three community health alliances, each including one to five hospitals. BayCare has also developed a clinically integrated network, called BayCare Physician Partners, which includes about 1,200 physicians. While some are employed by the system, the majority are in independent practice.

BayCare Health System's board of directors is made up of more than 20 community members and meets every other month. In addition, each community health alliance has a local board of directors.

An Exemplary Online Report Card

"Our organization was founded in quality," said Bruce Flareau, M.D., president of BayCare Physician Partners, and the executive vice president of physician affairs for BayCare Health System. "From the very day it was developed the CEO has always been a student of quality, and we have always had reporting from the ground up."

Every senior leader goes through quality training, and all employees (known as team members) are trained in quality and the quality model. This model builds from the ground up with a focus on customer needs, processes, and continuous improvement of those processes. It includes quality planning, quality improvement, quality assessment, and reporting.

"Our process improvement department looks at workflows throughout the system and identifies opportunities for improvement using the Lean Six Sigma methodology, which is based on continuous improvement and eliminating waste. We have 21 Lean Six Sigma Black Belts trained to facilitate and assist our various departments and team members in quality," said Charles DeShazer, M.D., chief quality officer for BayCare Health System.

Each year BayCare holds a "Quality Sharing Day" attended by board members, hospital leaders, and staff to celebrate initiatives various team members have developed and offer recognition for best achievements in various categories of service, outcome, and cost, and overall quality.

"One of the unique aspects of the BayCare system is that everyone is trained in quality and the quality model," Dr. DeShazer said. "Several years ago BayCare implemented an online tool called Team Map, which means each team member has an opportunity to define key metrics that they are personally accountable for. Typically they will be aligned with their yearly goals, as well as organizational goals."

The report card includes data from standardized patient satisfaction surveys (CAHPS), as well as data on Medicare spending per patient, for each of its hospitals, compared to national averages. It notes whether the measure is included in the quality measures reported to CMS. Since these are standard measures, it is possible for BayCare to compare its own results to national averages. "This online report card is just a beginning for us," the Web site

1 See www.baycare.org/quality-report-card.

states. "We plan to add more information on the site as national data continues to grow. We have also included a survey asking users what additional measurements they would like to see." The page includes an email address and phone number to call and inquire about the report card.

BayCare made a systematic effort to simplify the quality reporting on its Web pages, so the information is accessible for as many people as possible. This effort has resulted in a report card that really does offer interested patients important information about their care. For example, BayCare color-codes its results so a quality score statistically higher than the national average is coded green, while indicators are checked for which BayCare hospital was in the top 10 percent in the nation.

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> *—Bruce Flareau, M.D.*

The report card presents data from two time periods. Data from over a year ago is available because it can be compared with national averages. The Web site also features more recent data, which offers the best picture of BayCare's current performance, but cannot be compared with national averages since that information is not yet available. The information is updated every quarter.

The report card includes information on key processes of care and important clinical outcomes. For example, the process measures include:

- **Heart attack:** includes information on measures such as the percentage of heart attack patients given aspirin upon arrival, the percentage of patients given smoking cessation counseling, and the percentage of patients who receive percutaneous coronary intervention (PCI) within 90 minutes of arrival.
- **Heart failure:** includes data on percentage of heart failure patients who received discharge instructions, and were tested for left ventricular systolic function.
- **Pneumonia:** includes data on patients who were given the most appropriate initial antibiotic, and appropriate timing of a blood culture when performed.

The outcome measures include the 30-day mortality rate and the 30-day readmission rate, and are focused on heart attacks, heart failure, and pneumonia patients. They also include injuries and problems that occurred while the patient was in the hospital, blood infections from a catheter, or signs of uncontrolled blood sugar. This section of the report card also includes data on hospital-associated infections, such as infections related to an IV-line placed in a large blood vessel or vein.

Transforming Data to Patient Information

The BayCare quality report card offers a remarkable amount of useful information in relatively clear language. Patients who want to understand more about their care will find valuable clues here. Patients who are about to undergo surgery will be interested to know that in the days right after surgery it's especially important to keep blood sugar levels low, that they should get antibiotics before surgery to prevent infections, and that patients who are on beta blockers should continue taking them just before and after surgery.

The report card uses language most people can understand to describe statistical data: "A confidence interval [ratio] that is less than one means the hospital had fewer infections than hospitals of similar size and type. A confidence interval [ratio] that is more than one means the hospital had more infections than hospitals of similar type and size."

Healthcare system shorthand is translated for consumers who are not familiar with it. For example, the Web site explains that the 30-day readmission refers to a situation where patients who have been recently hospitalized go back into a hospital again within 30 days, and it notes that the measure has been adjusted to take into account how sick the patient was.

In addition, the report card also includes links to customer-friendly health information to help users interpret medical terms and evaluate specific measurements. For quality measures in which BayCare is performing below the national average, there is a link to information on steps the hospital is taking to improve that aspect of its performance.

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System-Wide Quality Reporting

The quality committee of the system board is comprised of the chairs of sub-regional quality committees, board members, the system CEO, community members, and others. "We are all about being a high-quality performing organization, and the system board consistently endorses and supports our quality efforts," Dr. Flareau said. The system quality committee reports at every board meeting.

In 2009, the system embarked on a three-phase, multi-year initiative to develop enterprise-wide scorecard reporting. "We

started to ask ourselves, how do we know the quality of care each division delivers?" Dr. Flareau recalled. "The board decided that the enterprise-level quality committee would oversee quality of all the care the system delivers, not just inpatient hospital care. We would develop quality scorecards for each of the areas. They would dovetail into the acute-care scorecard and, in totality, give us a broad look at the entire organization." He reflected, "Actually, this is the sort of quality reporting system you *must have* in order to maintain the health of a population. Back when we started working on it, very few organizations were familiar with the term 'population health.'"

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BayCare began to look more closely at the relationship between the system board and its subsidiary advisory boards. "We found our quality committees were examining the acute-care hospital space in a heavily focused way, with somewhat duplicative efforts," Dr. Flareau said. "We began to ask, what could we do differently to help us deliver a broader view of quality? For example, we offer a range of post-acute services, but there was no forum where all the team members who provide and manage post-acute could transfer knowledge and function as a learning organization, so that best practices are consistently handed off to each other."

The system instituted a clinical leadership council, a committee of all the clinical leadership of the system. Chief medical officers, chief nursing executives, directors of quality, and others reviewed all of the system's service lines, which includes home care, ambulatory surgical centers, outpatient imaging, employed physician practices, behavioral health services based outside the hospital, rehab centers, and skilled nursing facilities. The system determined that five categories of care delivered outside hospital walls warranted their own quality reports:

- Ambulatory care
- Home care
- Physician services
- Behavioral health
- Post-acute care

The first phase was an internal assessment that reviewed the current quality structure and currently used internal quality metrics. Phase two was an assessment of externally developed standardized, evidence-based quality metrics. "In phase one we looked at what we were doing, in phase two at what other people were doing. In phase three we are working to develop performance improvement and a mature quality report card for each of the areas," said Dr. Flareau.

One of the members of the clinical leadership council serves as a sponsor for each area, and meets regularly with that team. They self-monitor their performance, defining areas of opportunity and setting internal goals. That committee reports to the clinical leadership council, which reports up to the system-level board quality committee.

Post-Acute Settings Work Collaboratively for the First Time

The BayCare Health System includes several rehab centers and skilled nursing facilities, but previously they all reported upwards into different community health alliances. There was no forum or structure where all the departments responsible for post-acute care would sit together and share best practices.

Lisa Johnson, RN, B.S.N., was asked to head up the post-acute area. As chief nurse executive for four BayCare hospitals, totaling 1,200 acute-care beds, she is responsible for about 2,000 RNs plus 1,000 patient care technicians and support staff. "Chairing the post-acute work was something of a challenge since it meant stepping out of my familiar comfort zone and knowledge base, but the process has been remarkable in helping us to understand each other's experience, learn from each other, and work together to prevent readmissions," she said. "We developed real mutual respect. To me, that has been the biggest reward."

The post-acute team has been meeting monthly for the past three years, and in the initial stages they met more often. The process started by identifying the key players—the directors of nursing for all the post-acute facilities and departments. "At our kickoff meeting, people were literally meeting each other face-to-face for the first time," Johnson recalled. Their goal was to agree on one post-acute care dashboard, and use that dashboard for reports to the BayCare system board.

They started by brainstorming all the different ways to gather data. Each person checked with the subject matter experts at his or her institution, and brought back what they felt were the most important measures. "We looked at everything that gets reported internally, to regulatory bodies, to patient satisfaction groups, to anyone. We created a list of all the possible measures, and we were looking at 118 indicators," Johnson said.

Today the BayCare Health System post-acute care dashboard has nine measures:

- Patient satisfaction piece on likelihood to recommend
- Pressure ulcers per 1,000 patient days

- Falls per 1,000 patient days
- Significant medication errors (meaning errors that actually reach the patient)
- Catheter-associated urinary tract infections (CAUTI) per 1,000 catheter days
- Percentage of patients discharged to the community
- C. Difficile occurrence
- Percentage of patients discharged back to acute care
- Use of restraints per 1,000 patient days

One of the system's Lean Six Sigma Black Belts was available as a resource, and helped winnow down the measures and develop definitions. "He was tremendous in his efforts to keep us focused, and also to get the flow of data going," Johnson said.

It took several meetings to work out definitions for each of the nine measures. "It was worth spending quite a bit of time on definitions because we wanted to make apples-to-apples comparisons," Johnson said. "For example, we want to measure and prevent falls. At first, you think it will take about 20 minutes to work out the definition—after all, we all know what a fall is. Then you start looking more closely. Suppose someone falls but catches themselves by grabbing a handrail? Suppose the patient slips out of a chair? Within BayCare, we wanted to speak a common language, so we had to stop and think very carefully, what do we want to measure?"

Similarly, the group needed to develop standards in order to evaluate and measure C. Difficile in the same way in both acute- and post-acute care settings. The skin nurses, infection control nurses, and safety managers all agreed to measure C. Difficile the same (best possible) way, in both acute and post-acute settings (which previously had not been the case).

Selecting and defining the most appropriate quality measures in post-acute care has unleashed a flood of creative effort at improving care processes and outcomes. Throughout 2012, the post-acute team focused on these areas and saw significant improvements in several measures. For example, there was a 20 percent reduction on pressure ulcers per 1,000 patient days, compared to 2011. The likelihood that patients would recommend the hospital to friends and family, as measured by the HCAHPS survey, improved by 10 percent compared to 2011.

Achieving these results requires a host of small changes, improved communications, and great attention to detail. "In working on pressure ulcers, collaboration between skin nurses in the acute care and the post-acute care was a very important factor," Johnson said. "They discussed various barrier creams, supportive beds, and standardized treatment methods. They identified specific situations in which it is appropriate for the patient to leave acute care with a specialty bed to prevent deterioration."

Having seen significant improvements on the nine post-acute quality measures, in 2013 the post-acute team is placing particular emphasis on handling discharges in the most appropriate way, and reducing unnecessary readmissions back to the hospital. "In the acute-care area, we can work so patients arrive at the post-acute setting at an appropriate time (early in the day)," Johnson said. "When they reach the new setting they should have a clear treatment plan in place and medications available from day one."

Early planning and establishing communications with family members is also essential, she said. "We're in Florida. Often family members come down here during an acute episode, but then they have to leave and get back to work. It's so important to talk with them throughout the hospitalization, so they understand what will happen during the early post-acute period."

Another challenge for the post-acute team in 2013 is that two additional hospitals will enter the program. "We are already brainstorming together with them. They both have large post-acute areas, and we're eager to have them be part of this program. Hopefully we'll learn from them, and vice versa," Johnson said.

Next month she will present a report to the system board about the system's post-acute quality improvement efforts. "We have done three previous presentations to the board about post-acute care dashboard development," Johnson said. "They've been extremely supportive. At the same time they definitely ask probing questions that make us go back and think about alternate ways of working on this. When we see an improvement, do we know *why* we improved? Are we able to replicate that improvement? When we find that a particular department does well on an indicator, what are they doing differently? Are we all learning from them? The board uses questions like that to hold us accountable, as they should."

Physician services is another area for which BayCare is developing improved quality reporting. The system has seven different companies that employ physicians, and it is in the process of bringing them together under a single umbrella. "Long before we looked at consolidating those practices we focused on the care physician office practices deliver and asked ourselves, how do you measure this?" Dr. Flareau said. "At that time some were certified as medical homes. Today almost all of them are level-three certified medical homes."

Just as in the post-acute area, the physicians found it took a great deal of work to develop common definitions of key measures, even common events that you would think would be simple to define. "Everyone agrees that appointment availability is important," Dr. Flareau recalled. "But some offices were monitoring same-day appointment availability, some looked at available appointments by the third day, and some looked at missed

appointments. It took us many months to sit down and talk in detail about what is most important to track, and how exactly do you define it and measure it?"

For historical reasons, the practices use different electronic medical records; even though they all intend to gather similar information, the details are different. One clinic may ask whether the patient smokes now, and how much. A second clinic may ask, has the patient ever smoked in the past, and do they smoke now? A third clinic asks whether they are exposed to other smokers at home. Because the clinics are locked into different information-gathering systems, aggregating this information is not a simple matter.

In spite of these obstacles, the physicians have developed a consolidated scorecard report that includes measures such as childhood immunization rates, HbA1c testing, colorectal cancer screening rates, 30-day readmission rates, and the patient's experience of care.

The next step will be to pull materials together to demonstrate trends over time. "Eventually we will be able to make this information available to physicians and show them their own scorecard report. At present we are less mature in the integrated network data reporting space, but this is an important area where our efforts will produce significant results in due time," Dr. Flareau said.

BayCare is gathering a wide range of data on all its services, and over time the system plans to share more and more data with potential patients. Eventually, BayCare patients who are in the process of choosing a nursing home or other non-hospital services will be able to access a wealth of quality data on the system's effectiveness in caring for people across the entire continuum of care.

Transformative Steps Towards a Fully Integrated System

"One of the most important things we learned is that data definitions really do matter," Dr. Flareau said. "If you want your organization to become a learning organization, you need to invest time in understanding and developing precise data definitions. You must determine what you want to measure, agree on measuring it in a specific way, and fully integrate that definition into cultural understandings and agreements throughout the organization. This process takes more time and energy than people may recognize when they first embark on these quality efforts. We have definitely found that it is a worthwhile journey."

Many systems are still evolving from a hospital system to a health system, Dr. Flareau explained. "Making the transition to a health system and developing the competencies to deliver population health means looking beyond the hospital space, thinking about how to manage care beyond the hospital space. Since developing a scorecard for physician care, we have spent an enormous amount of energy looking at the way our clinically integrated network reports quality. In fact, BayCare Physician Partners made the chair of the clinical performance committee a voting member of the system-level quality committee, and put a standing report on quality on every agenda."

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"The transparency aspect of these programs is transformative," said Dr. DeShazer. "In these ongoing meetings on quality I personally experience a level of transparency and openness that is truly remarkable. There's a willingness to discuss the results, what they mean, and most of all what is driving those results. This open-minded inquiry helps facilitate quality improvement throughout the system."

Johnson agreed. "The collaborative relationships that are formed are almost priceless," she said. "This communication process encourages people to look beyond their own walls. You really see relationships forming, people picking up the phone and calling each other, knowing who has expertise to share. Our experience has been that creating communication channels allows you to create your own best practice, evidence-based environment, so people don't have to continually reinvent the wheel."

Elaine Zablocki, freelance journalist and staff writer for The Governance Institute and National Research Corporation, has been reporting on healthcare for more than 20 years. She has written many articles for The Governance Institute's BoardRoom Press, *as well as* WebMD, Medicine on the Net, Quality Letter for Healthcare Leaders, *and* Great Boards Newsletter.