

All Quality is Local

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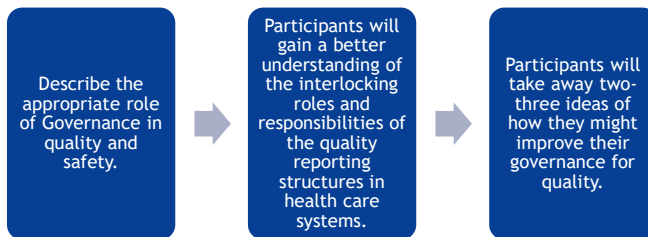


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Session Objectives



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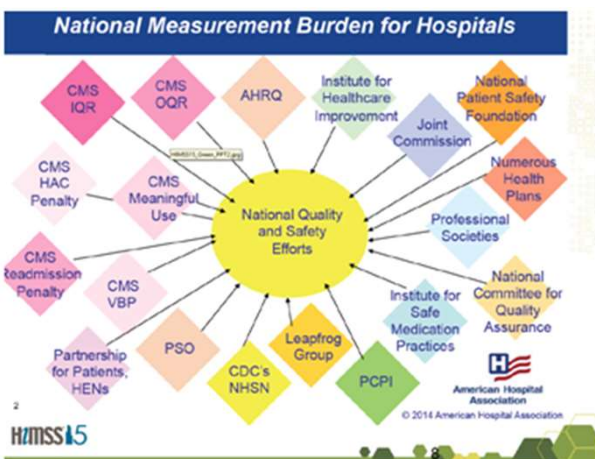
“All politics is local.”

Thomas Phillip "Tip" O'Neill Jr.
Former Speaker of the House

People are engaged by what matters to them

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Observation about Board Quality Committees in 2021



- **In many organizations, Quality Governance has become a static process.**
 - Reports are primarily focused on measures being collected and reported externally
 - Too much detail
 - Few questions by board members
 - Little differentiation of types or relative importance of measures
 - Little discussion of improvement strategy
 - Scant focus on desired organizational outcomes
 - Physician members tend to focus on individual clinical or research interests
 - Reporting often reflects what the quality management department is doing in their daily work
 - More about management activities as opposed to actual governance
- **Mirrors the approach of old-style hospital Finance Committees with detailed review of financial statements and budget variances as opposed to real discussion about improving financial performance**

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Finding the right level of review...

It makes about as much sense for system-level quality governance to be reviewing and comparing CLASBI rates as it does for the system-level finance committee to be reviewing and comparing ICU supply costs.

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Hospital/System Financial Governance

- In the beginning, approval of all check requests and expenditures (60-70's)
- Followed by approval of capital and operating budgets rather than expenditures... (70's-80's)
 - Evolving into a detailed review of operating report budget variances...
- Followed by a focus on financial statements and revenue streams...(80's-90s)
- Followed by a focus on investment portfolio performance..(90's)
- Followed by a focus on credit ratings and overall financial performance...(2000's)
- Followed by a focus on revenue diversification, access to capital and asset positioning... (2010's)
- 2020's ??

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Evolution of Quality Governance

- In the beginning, medical staff credentialing...(60-70's)
- Then, a focus on risk management...(80's)
- Then, a focus on accreditation...(90's)
- Then, a focus on patient satisfaction...(early 2000's)
- Then, a focus on patient safety...(late 2000's)
- Then, a focus on reported quality and safety measures...(2010's)
- Then, ??...

“You don't fatten a cow by weighing it.”
Old Middle East Saying

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2020's Focus on Outcomes and Set Expectations

- Focus on outcomes and create expectations for performance:
 - The system-level board should view a simple dashboard of a few high-level outcome measures that can be rolled up to reflect overall system performance and the system's quality strategy.
 - The measures and targets should reflect the important dimensions of quality/ safety and can be used to create organizational alignment to achieve system-wide performance goals.
 - Local or next level governance review should start with a comparison of local performance to system outcome aims and expectations.

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Think Differently: What Matters to Patients

**Don't hurt me
Help me
Be Nice to Me**



Don Berwick, MD

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At the highest level of governance, focus on outcomes

Potential Categories

- Patient safety/harm reduction
- Clinical Care
- Patient Experience
- Access
- Equity
- STEEP

Possible Outcome Measures

- Patient Harm Index
- % of patients receiving “right care”
- Hospital Mortality Rate
- % of patients who “would recommend”
- % of patients seen within a specified time frame
- Hospital mortality or “right care” by Race
- Community/Population Health Index by subgroups

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Setting expectations: Ask the right questions



What are the important quality and safety results we should be monitoring?

How good do we want to be?

Where is our performance now?

Where should our performance be?

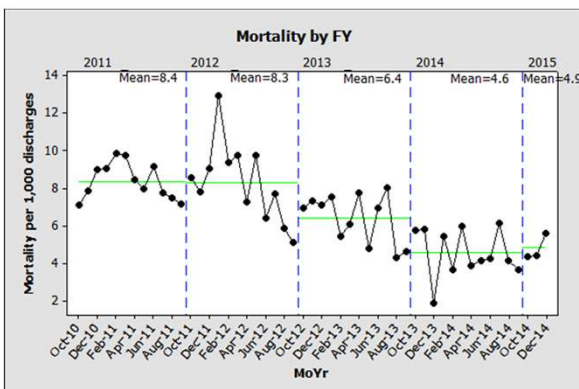
When should we expect results?

How does our strategy move this measure?

What resources are we committing to this effort?

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Focus on Desired Outcomes: Set Aggressive Aims



- Reduce overall mortality (excluding inevitable mortality) by 50% by 2015.

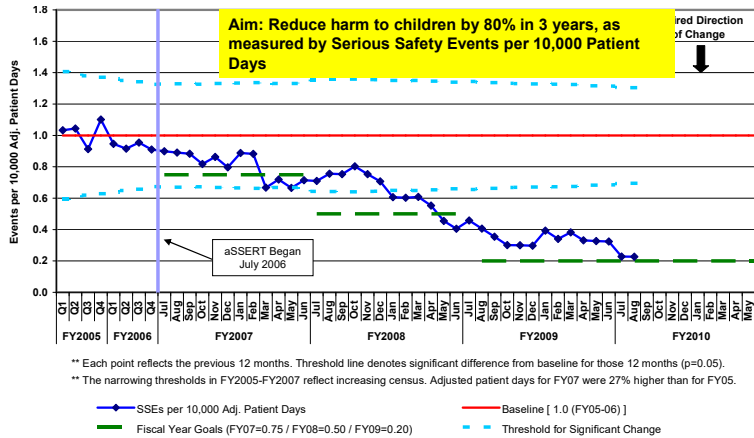
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Focus on Desired Outcomes: Set Aggressive Aims

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Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average



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What story are you trying to tell?



MENDOCINO COAST DISTRICT HOSPITAL'S INTEGRATED QUALITY MANAGEMENT 4th QUARTER 2017 SCORECARD

INDICATORS	GOAL %	1 st Q 2017	2 nd Q 2017	3 rd Q 2017	4 th Q 2017
Patient Experience	90%	81.1%	82.5%	86.1%	86.0%
Care Measures	90%	98.0%	81.6%	94.5%	94.0%
Tract Infection	<1.8%	0%	0%	0%	0.8%
Medication Errors	<1.8%	0%	0%	0.2%	0.0%

Augusta Health (490018) Hospital Quality and Patient Safety Scorecard

Measure - Name	Hospital Score	1-Year Change
Central-Line Associated Blood Stream Infections (CLABSI)	0.60	+0.60
Catheter Associated Urinary Tract Infection (CAUTI)	2.35	+1.48
30-Day Compliance/Patient Safety for Selected Indicators	0.95	+0.06
Heart Attack (AMI)	15.5%	-0.50
Heart Failure	16.6%	-2.60
Pneumonia	16.2%	-1.20
Hip/Knee Replacement	4.1%	+0.30
30 Day Hospital All-Cause Unplanned	14.4%	-0.30
Heart Attack (AMI)	12.1%	-0.30
Heart Failure	13.3%	-0.80
Pneumonia	14.8%	-2.70
Overall Hospital Rating 0-10	71.0%	+5.00
Medicare Spending Per Beneficiary	0.92	+0.02

Legend: Red = Below, Yellow = Meets, Green = Exceeds, N/A = Not Available

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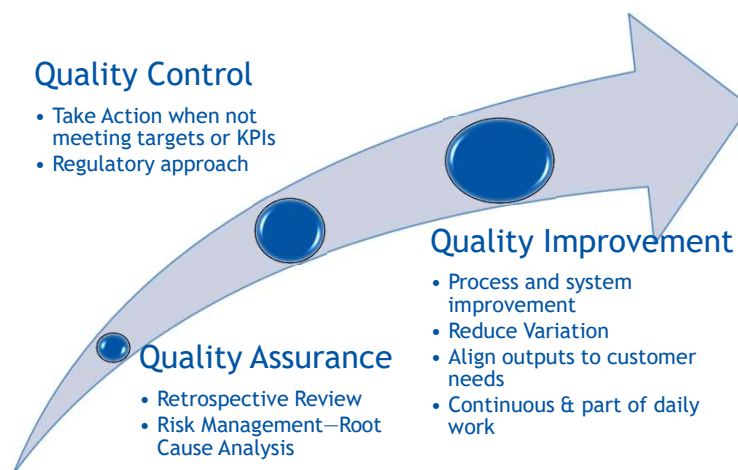
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Create context for measures and scorecards

- Management can create context for the measures reported by organizing them differently.
- Instead of a single long report or scorecard, measures should be organized and grouped to tell specific stories.

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Think Differently: These are not the same



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One Dashboard Does Not Fit All

Main Street Hospital FY 2018 Board Performance Scorecard		Exceeds Target	Meeting Target	Below Target			
	3 Year Goal	FY Target Range	Prior Year	FY 18 QTR 1	FY 18 QTR 2	FY 18 QTR 3	FY 18 QTR 4
CULTURE							
Employee Turnover Rate (Unplanned)	3% per quarter	5.5-6% per quarter	7.50%	2.41%	2.84%	4.00%	2.80%
Employee Satisfaction (% Recommend as Place to Work)	90%	60-70%	47%	75%	78%	80%	73%
PREVENTING HARM (Safety)							
Falls with injury (Quarterly)	0	2-4 per Quarter	22 (FY)	4	3	3	4
Number of Patients Harmed from ADE	0	5-10 per Quarter	102 (FY)	13	15	7	3
# of Central Line Infections	0	0	9 (FY)	5	3	5	0
# of Ventilator Associated Pneumonia	0	0	6 (FY)	2	2	3	2
# of Pressure Ulcers	0	8-12 per Quarter	72 (FY)	20	28	10	12
CLINICAL QUALITY							
EVIDENCE-BASED CARE % OF PATIENTS RECEIVING ALL REQUIRED ELEMENTS							
Acute MI	100%	90-95%	88%	96%	96%	95	97
Pneumonia	100%	80-90%	75%	98%	88%	95%	93%
Congestive Heart Failure	100%	90-95%	85%	90%	98%	95	92
Hospital Infection Rate (Per State Reporting Criteria)	5%	9-11%	14%	13.0%	14.1%	11.6%	10.5%
Unplanned Readmission Rate	0%	4-5.5%	8%	5.0%	5.1%	5%	5%
# of Inpatient Deaths (unplanned, non-comfort care mortality)	0	3-5 quarter	28 (FY)	8	8	7	5
FINANCIAL HEALTH							
Contribution Margin %	8%	2.5 to 4%	1.50%	2.60%	3%	3%	2.9%
Days Cash On Hand	180 days	80-90	65	88	80	80	81

- **Rethink your quality scorecard and measure presentations**
 - Why are you reporting these measures?
 - Simplify
- **Re-organize your Quality data presentations:**
 - Strategic Quality/Organizational Outcomes
 - *A few high-level measures of patient experience, mortality, clinical effectiveness, safety*
 - Quality Control Measures—
 - *process measures that are being monitored and/or reported externally*
 - Improvement Measures
 - *Specific quality improvement efforts actively being pursued*

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Measures and Scorecards Should Be Aligned to Function



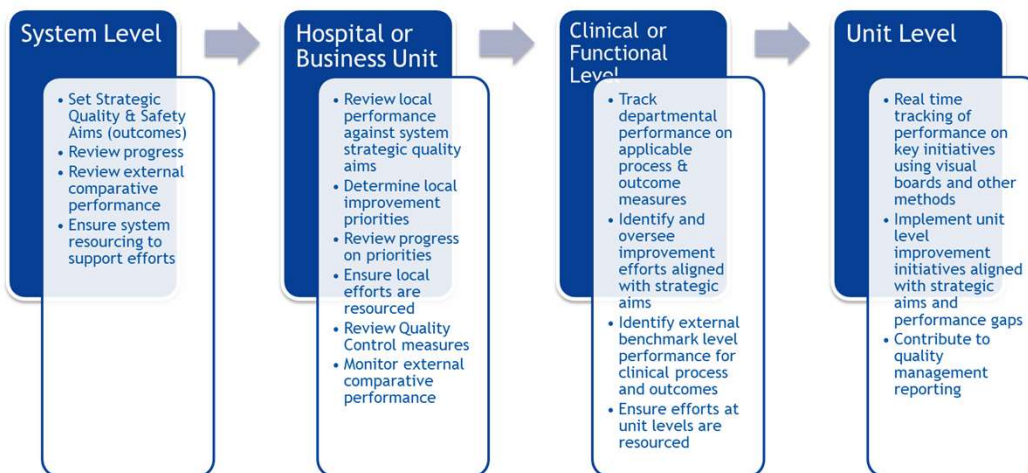
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Governance, Leadership and Management Functions Overlap—The challenge is staying in your lane



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Quality Governance Cascade



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Reflection Questions for Boards and Leadership



- Are you seeing the forest or the trees?
 - Lots of measures, but little information?
- Are you re-reviewing data and reports that have already been reviewed at other levels?
 - If so, why?
- Is the level of detail appropriate for the level of governance?
 - Is there a clear reporting cascade of aims and measures?
- Are you setting quality aims and expectations or simply approving reports?
 - Are quality and safety strategic in your organization?
- Are you asking why?
 - Discussions focus on “what” rather than “how” or “why”

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Quality happens when staff are engaged in what matters to patients.

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Questions?



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Contact Information



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