Inova Fairfax Hospital

Karin Cox, RN, MSN,
Quality Consultant: Critical Care & Neurosciences Services

INOVA® FAIRFAX HOSPITAL

Inova Fairfax Campus

- **833 licensed beds**
- **2 million square feet**
- **36 Off-site properties**
- **>7,000 employees**
- **Quality Staff of 13.5**
- **Outcomes Staff of 16**

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What we will cover

- History of Quality Efforts in Healthcare
- What is an Ideal Healthcare System
- Role of the Quality Consultant
- Quality at Inova Fairfax Hospital

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The Quality Professional's Perspective

- Do the Right Thing Right, the First Time
- Continuous Process Improvement
- Timeliness
- Reliability
- Efficacy
- Availability
- Affordability
- Standardization
- Freedom from Deficiencies
- Customer Satisfaction

Quality from the Patient's Perspective

- Keep me safe
- Heal me
- Be nice to me

  In that order!

Safety + quality + satisfaction = Excellent Care

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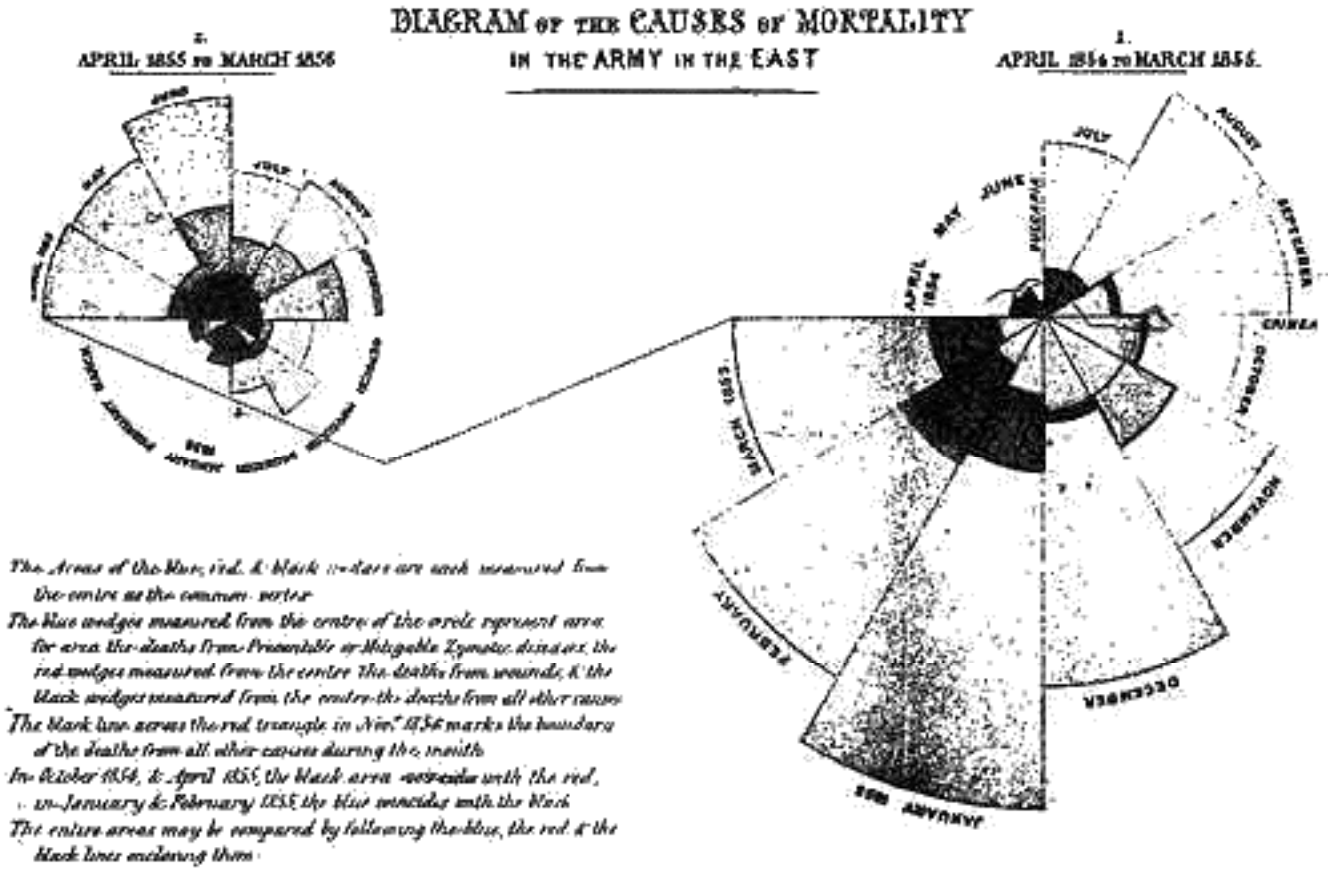
Measuring Quality: Romeo and Juliet

- I do remember an apothecary,--
  And hereabouts he dwells,--which late I noted
  In tatter'd weeds, with overwhelming brows,
  Culling of simples; meagre were his looks,
  Sharp misery had worn him to the bones:
  And in his needy shop a tortoise hung,
  An alligator stuff'd, and other skins
  Of ill-shaped fishes; and about his shelves
  A beggarly account of empty boxes,
  Green earthen pots, bladders and musty seeds,
  Remnants of packthread and old cakes of roses,
  Were thinly scatter'd, to make up a show.

History of Quality: Florence Nightingale

- Went to Scutari Hospital with 38 nurses
- 3,000 – 4,000 soldiers
- Deplorable conditions 43% mortality
- Set up kitchens, laundry, basic sanitation, nursing
- Mortality dropped to 3%
- Nightingale Fund allowed independent endowment of St. Thomas School of Nursing

Florence Nightingale as statistician



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Foundation of Process Improvement

- Set Standards
- Measure

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Voluntary Standards Formed

- 1913 – American College of Surgeons founded
- 1917 – Minimal Standards for Hospital – five
  - Physicians had to be graduates of School of Medicine
  - Physicians had to apply for Medical Staff privileges
  - Organized Medical Staff had to meet at least annually to review quality of care
  - Medical Record
  - Hospital services supervised by a qualified person

Voluntary Standards Formed

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  - Hospital services supervised by a qualified person

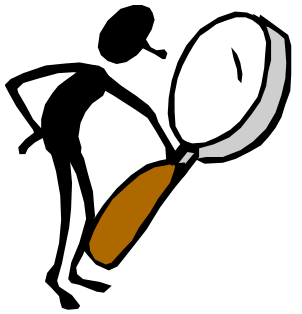
- **1918 – First inspection**
  - **Only 89 out of 692 hospitals met standards**

Pressure to Change: Standards Evolve

- 1950s A time of change
  - Number of standards increases
  - 3,200 hospitals achieve standards
  - American College of Physicians, American Hospital Association, American Medical Association, Canadian Medical Association form the Joint Commission on Accreditation of Hospitals
- 1965 Congress passes Social Security and “deems” that hospitals accredited by JCAH are able to participate in Medicare
- 1970s Expansion and Segmentation
  - Nurses, Hospital Administrators, Dentists
  - Required submission of remediation plans

Pressure to Change: Standards Evolve (TJC)

- **Develop Standards for Different Types of Organizations**
  - Hospitals
  - Behavioral Health
  - Ambulatory Care
  - Home Care
  - Critical Access (Rural) Hospitals
  - International
- **Develop Disease Specific Standards (as of 2002)**
  - Stroke
  - Cystic Fibrosis
  - Renal Disease



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Standards Proliferated in Many Areas

- **Rights and Ethics**
- **Provision of Care**
- **Medication Management**
- **Infection Control**
- **Performance Improvement**
- **Environment of Care**
- **Leadership**
- **Medical Staff**
- **Nursing**
- **Human Resources**

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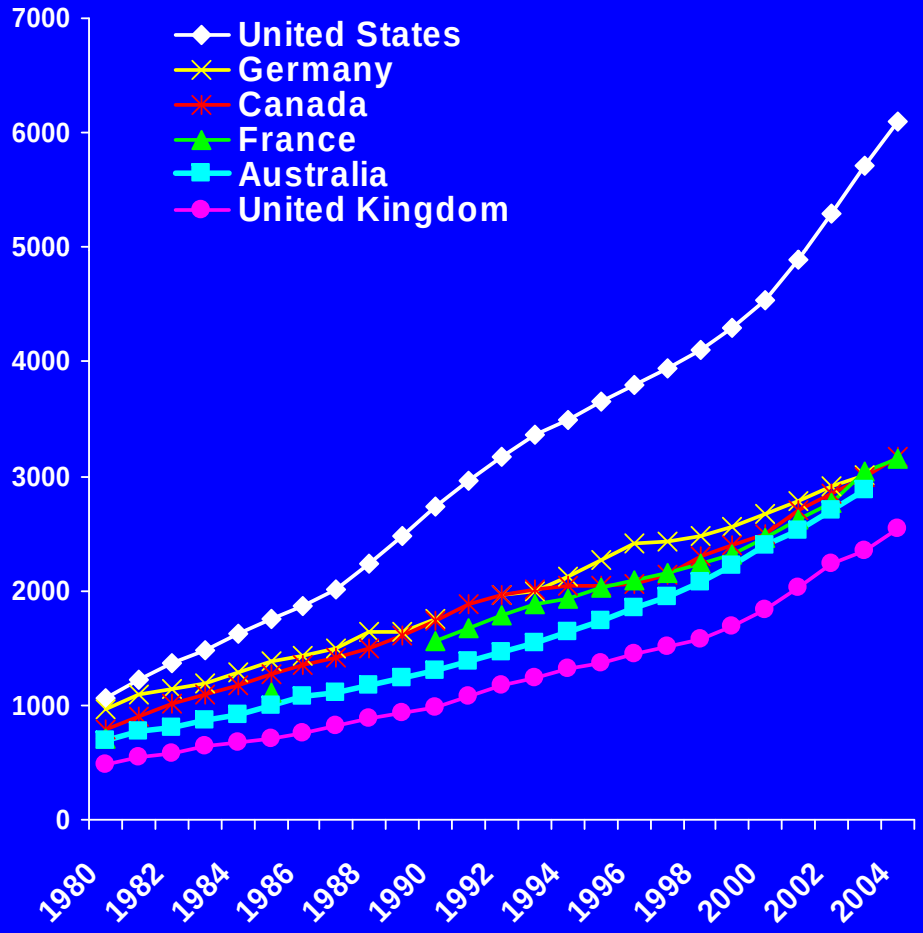
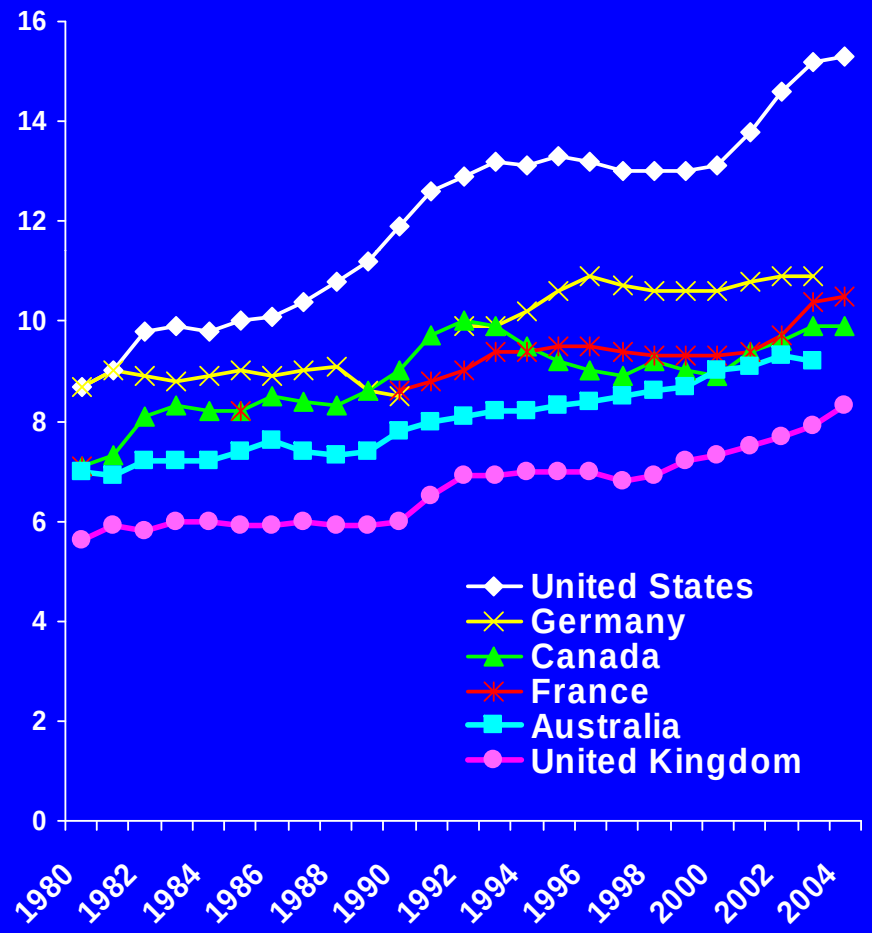
International Comparison of Spending on Health, 1980–2004

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



Data: OECD Health Data 2005 and 2006.

16

Wake Up Call in Public and Private Sectors

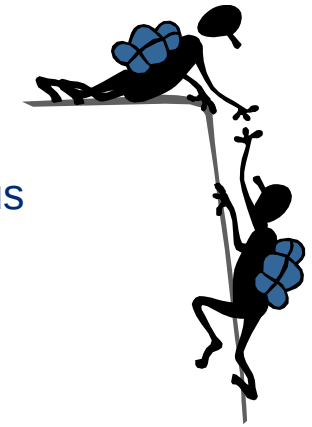
- Fee for Service
  - Rewarded utilization
  - No incentives for quality
  - Discount in exchange for volume
- Prospective Payment – Public Sector
  - DRG (Diagnosis Related Groups)
- Prospective Payment – Private Sector
  - HMO's
  - Capitation

Standards Evolve

- **Joint Commission 1980s "Agenda for Change"**
  - Response to Criticism
  - First "Public" members
  - Outcome Measurements: Core Measures 1987 - 2001
  - Sentinel Events

Different Approaches

- **TJC**
  - Primary
    - Processes of care, continuum, communication, continuous improvement
  - Secondary
    - Inspection, deficiencies



- **CMS**
  - Primary
    - Inspection, deficiencies
  - Secondary
    - Processes of care, continuum, communication, continuous improvement

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Was it enough?

- We created standards
- We measured to these standards

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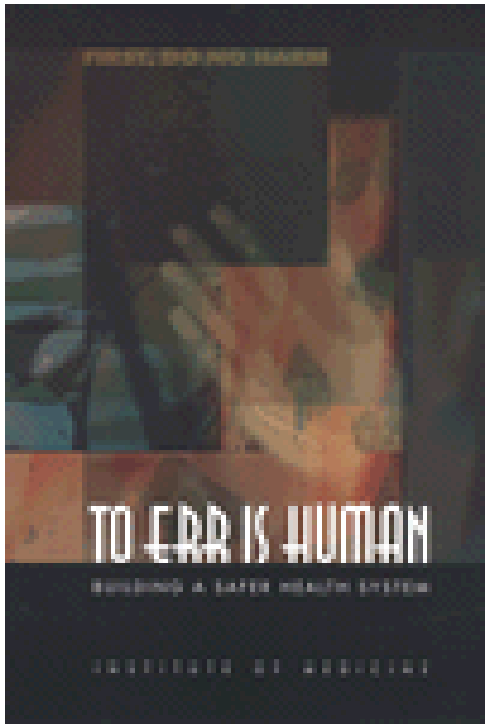
To Err is Human

- Published 2000 by Institute of Medicine
- Adverse events occur in 2.9 to 3.7 % of hospitalizations
- 33.6 million hospitalizations per year in United States
- 44,000 to 98,000 adverse events per year
- Adverse events result in death 6.6 to 13.6 %
- Death due to medical errors as 8th leading cause of death



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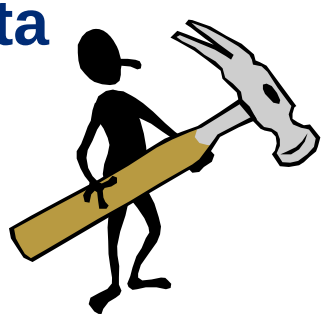
Responding to IOM

- **Reduction in Federal reimbursement by 2% for not submitting data on Core Measures: How often a hospital adheres to evidence based clinical practice for heart attack, heart failure, pneumonia, surgery (2003)**
- **Transparency: Public website to display Core Measures results (2005) www.hospitalcompare.hhs.gov**
- **Reduction in Federal reimbursement by 2% for not submitting HCAHPS patient satisfaction data (2007)**



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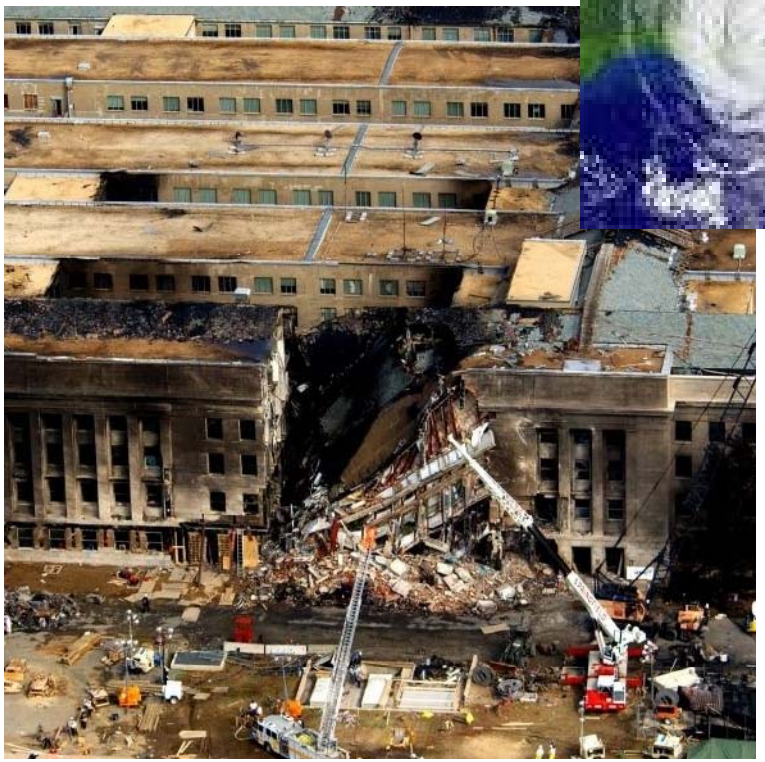
National Events



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JOSIE KING FOUNDATION at BCF
creating a culture of patient safety, together

THE LEAPFROG GROUP
Informing Choices. Rewarding Excellence.
Getting Health Care Right.

The Joint Commission

NQF
National Quality Forum

CMS Centers for Medicare & Medicaid Services

Welcome to
CALNOC
Collaborative Alliance for Nursing Outcomes

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

INSTITUTE FOR HEALTHCARE IMPROVEMENT

American Hospital Association

NDNQI®
NATIONAL DATABASE OF NURSING QUALITY INDICATORS

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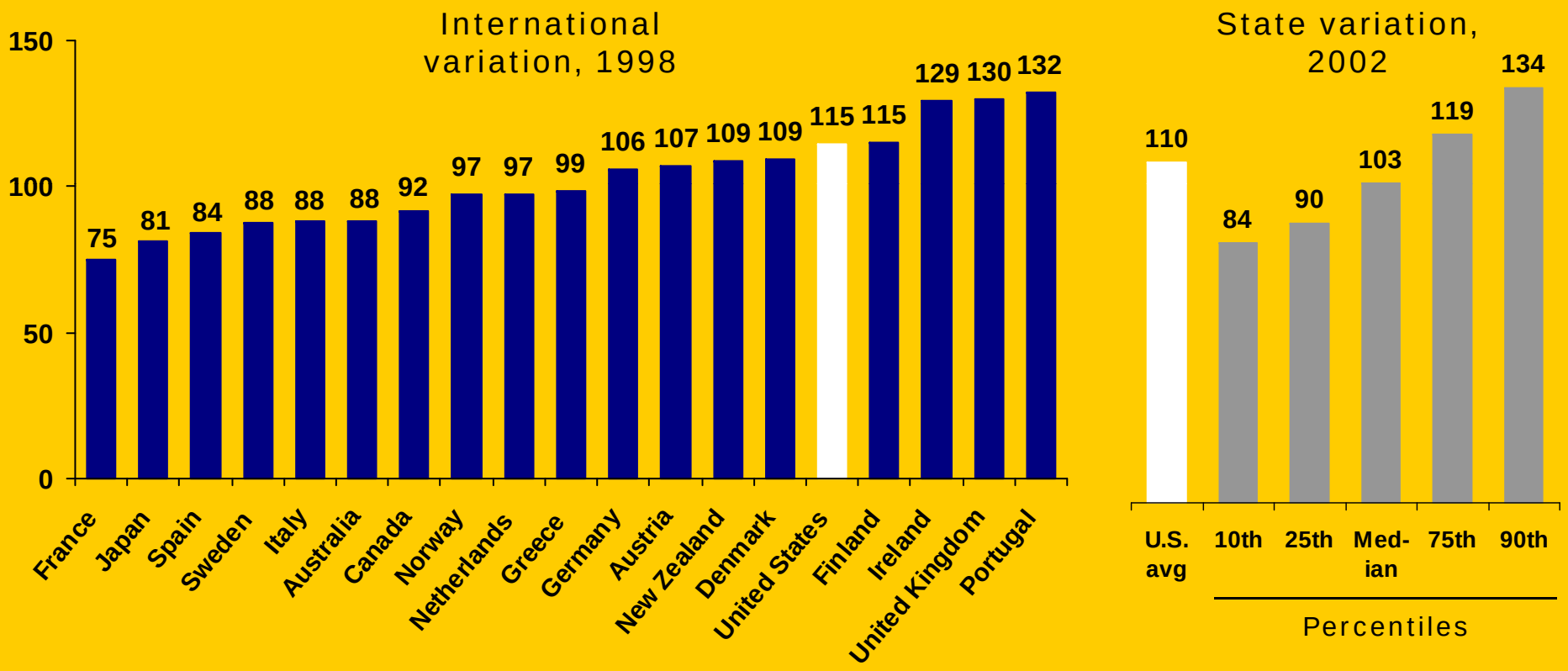
Components of an “Ideal” Health Care System

1. Long, healthy, productive lives
2. Quality
3. Access
4. Efficiency
5. Equity
6. Capacity to innovate and improve

Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

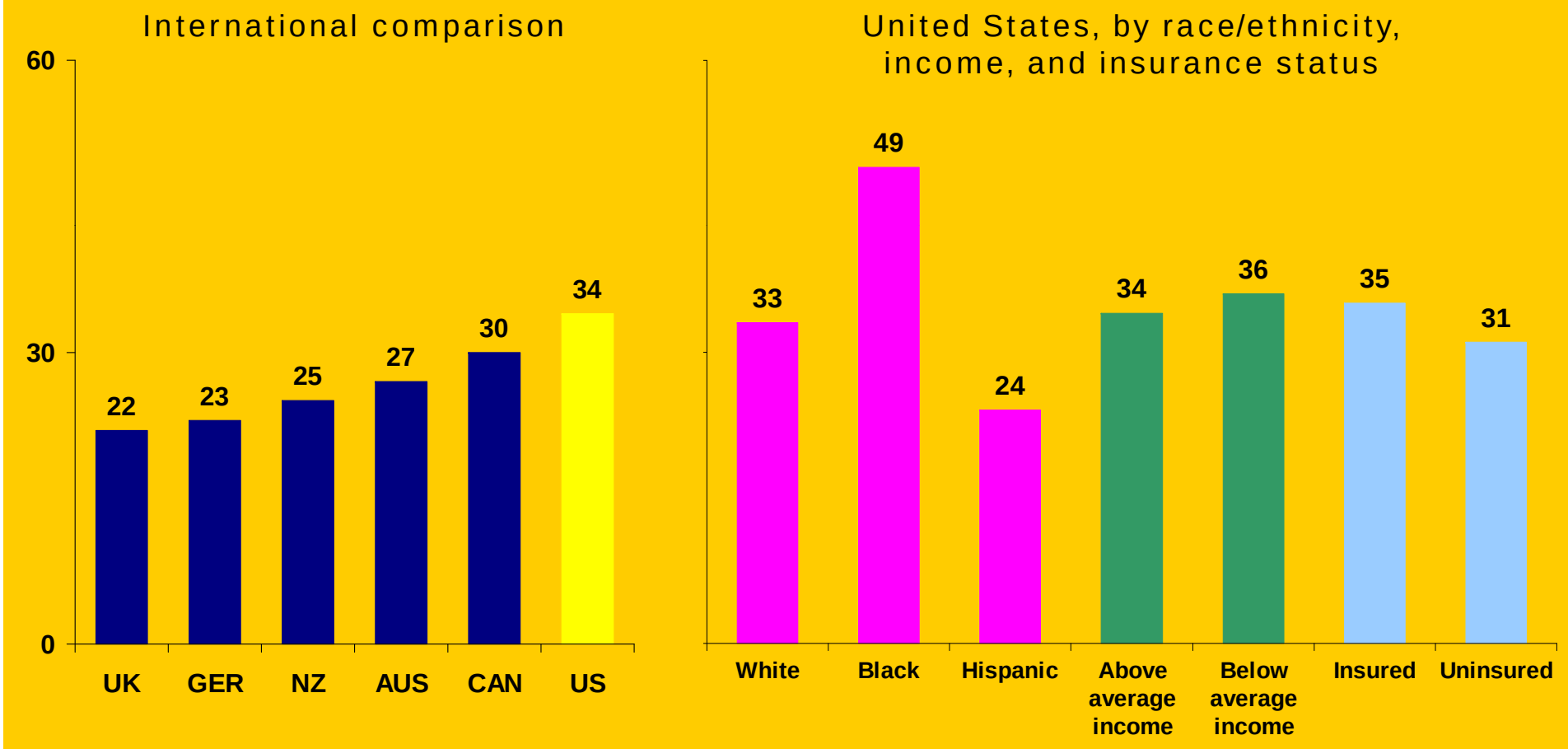
Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003);
State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

Medical, Medication, and Lab Errors Among Sicker Adults, 2005

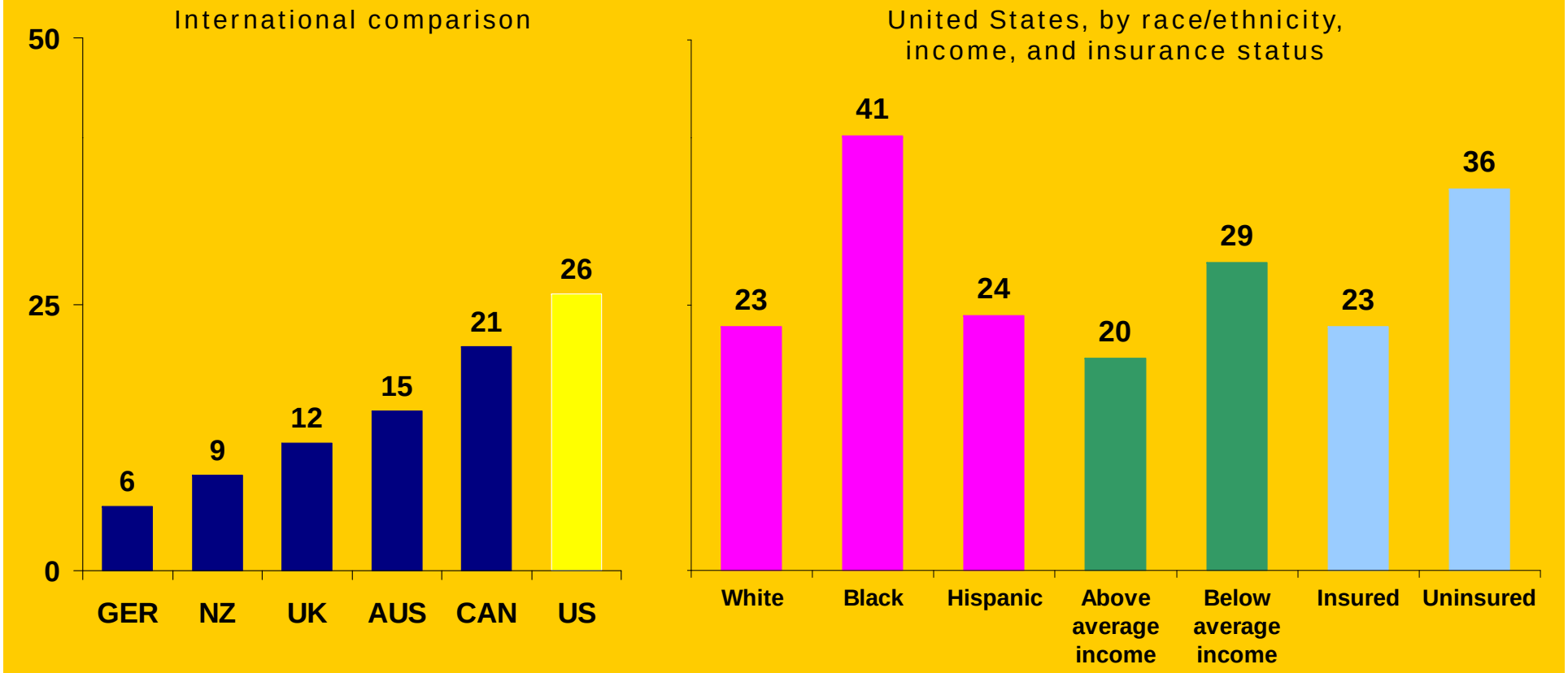
Percent reporting medical mistake, medication error, or lab error in past two years



UK=United Kingdom; GER=Germany; NZ=New Zealand; AUS=Australia; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.

Went to ER for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults, 2005

Percent of adults who went to ER in past two years for condition that could have been treated by regular doctor if available



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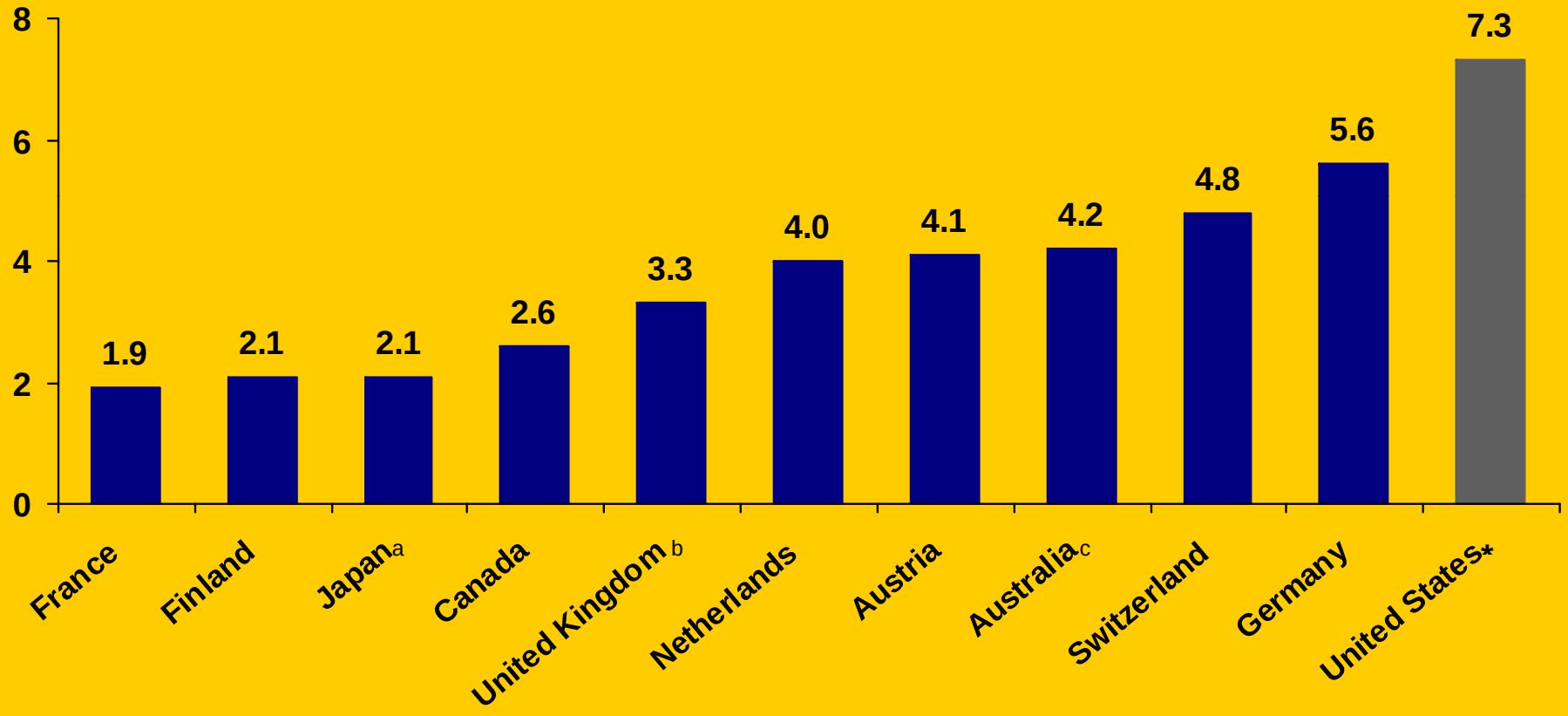
Percentage of National Health Expenditures Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance as percent of national health expenditures



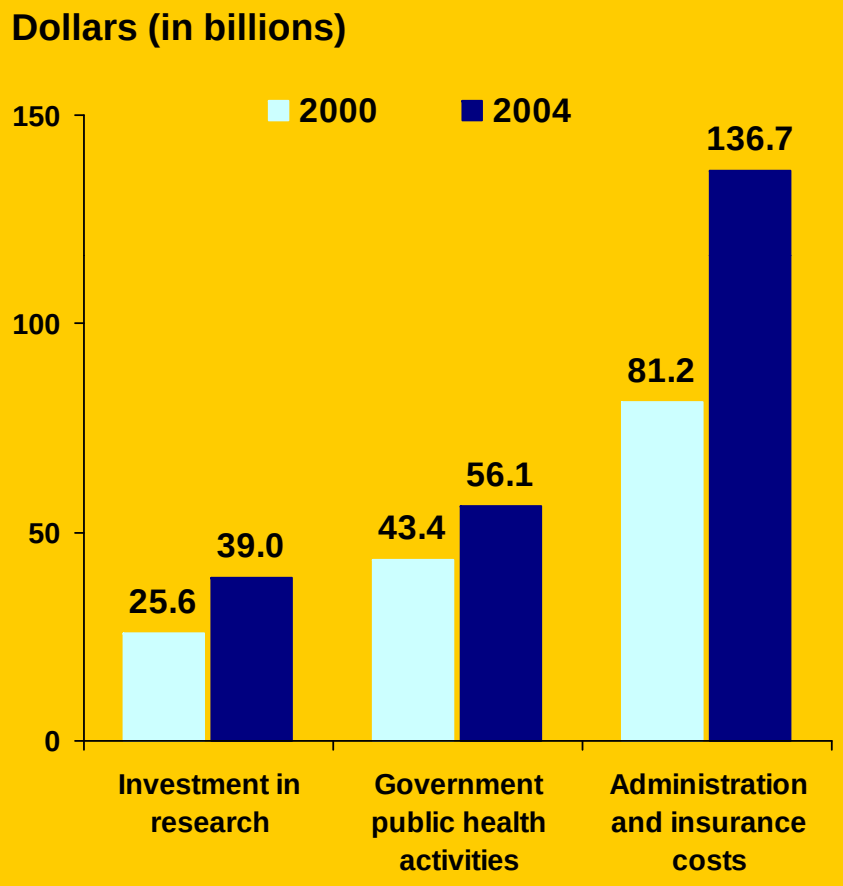
[a] 2002 [b] 1999 [c] 2001

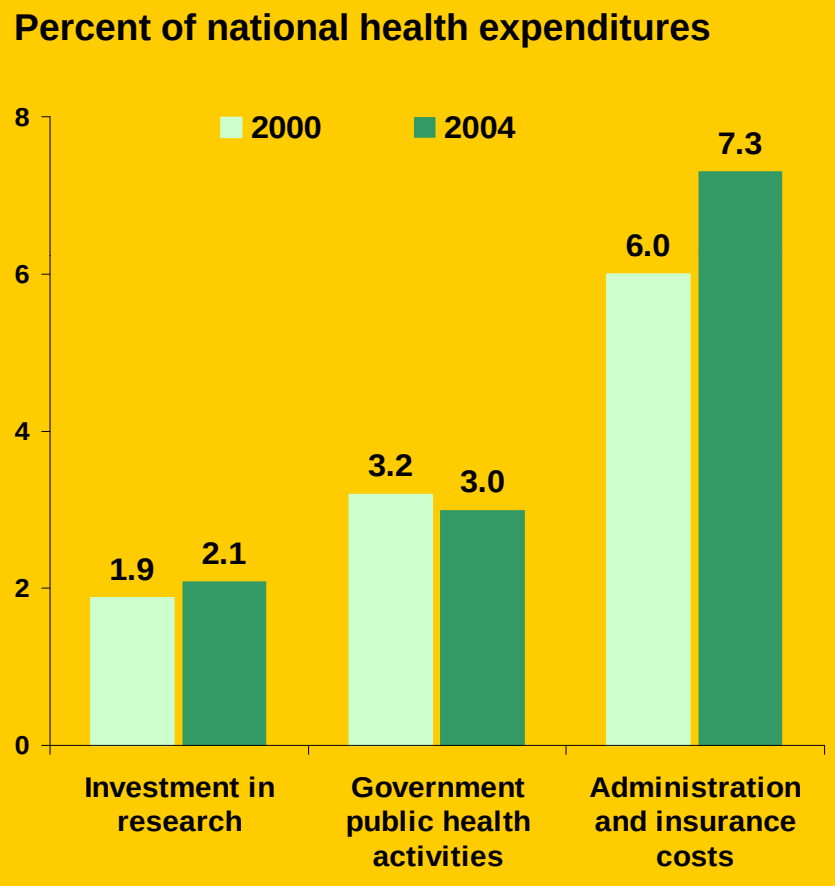
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Data: OECD Health Data 2005.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

National Health Expenditures Invested in Research and Spent on Public Health Activities Compared with Administration and Insurance Costs, 2000 and 2004





Data: CMS Office of the Actuary, National Health Statistics Group; and U.S. Dept. of Commerce, Bureau of Economic Analysis and U.S. Bureau of the Census (Smith et al. 2006).

Scorecard-Related Publications

- Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475. Available online at:
  http://content.healthaffairs.org/cgi/reprint/25/5/w457
- Commonwealth Fund Publications:
  - Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (Sept. 2006).
  - Cathy Schoen and Sabrina K. H. How, *National Scorecard on U.S. Health System Performance: Technical Report* (Sept. 2006).
  - Cathy Schoen and Sabrina K. H. How, *National Scorecard on U.S. Health System Performance: Complete Chartpack* and *Chartpack Technical Appendix* (Sept. 2006).

  These Fund publications are available for free download on The Commonwealth Fund's Web site at www.cmwf.org.

Where are we now with Quality: Financial Accountability

- 1987 - 2002: Hospitals were required to collect data and report on standardized – or “core” – performance measures. Failure to report results in reduced reimbursement.
- Core Measures
  - Acute Myocardial Infarction (AMI)
  - Heart Failure
  - Pneumonia
  - Surgical Care
  - Asthma

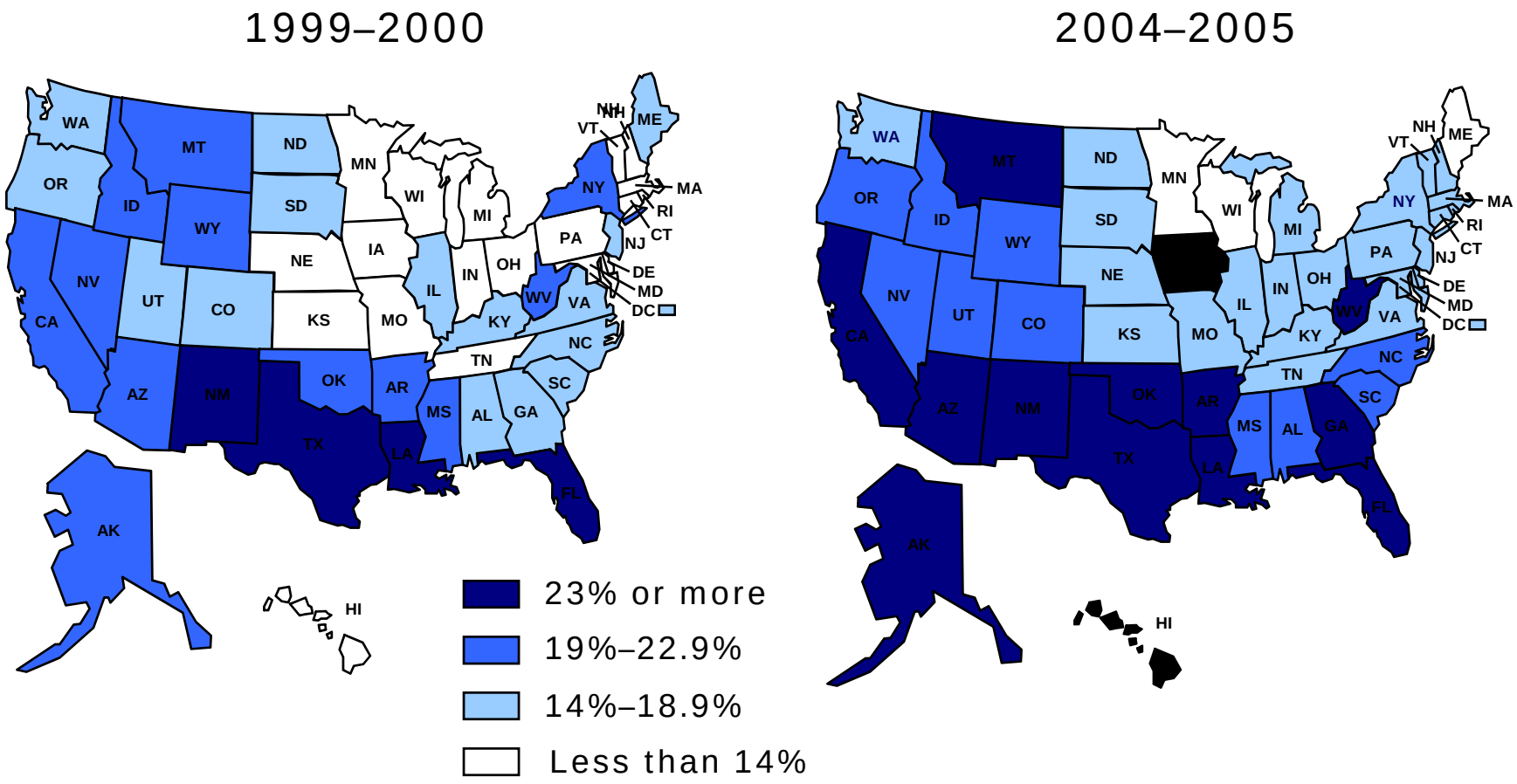
Where are we now with Quality: Financial Accountability

- 2008: Reduced reimbursement for HACs
- Hospital Acquired Conditions
  - Specific types of Infections
  - Injury during hospitalization (fall, burn)
  - Retained foreign body
  - Skin breakdown stage III or IV
  - Wrong surgery
  - Blood transfusion mis-match
- “Never” events

Where are we going?

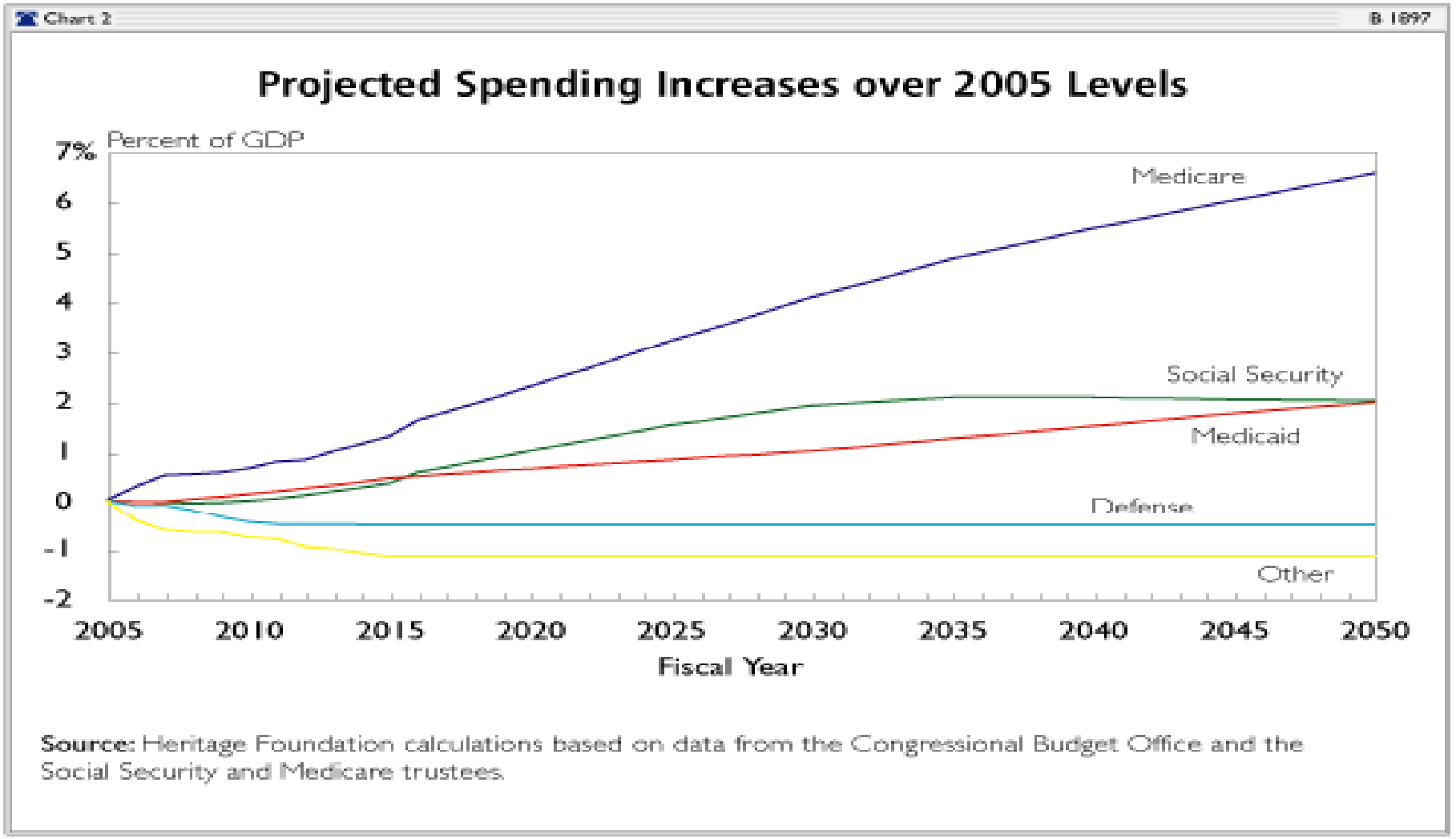
- Pressure on Federal Government to act
- Many different stakeholders
  - Providers
  - Payors (Government, Private)
  - Regulators
  - Suppliers
  - Patients/Families
- Recognition of the cost of poor quality
- Leverage use of technology

Percent of Adults Ages 18–64 Uninsured by State



Data: Two-year averages 1999–2000 and 2004–2005 from the Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Surveys. Estimates by the Employee Benefit Research Institute.

Federal CMS (Medicare/Medicaid)



Quality from the Patient's Perspective

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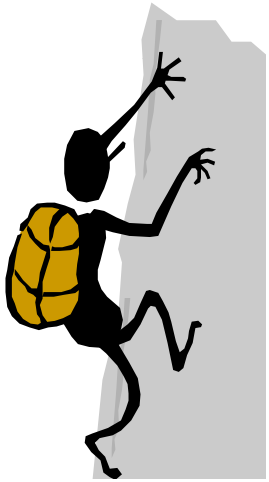
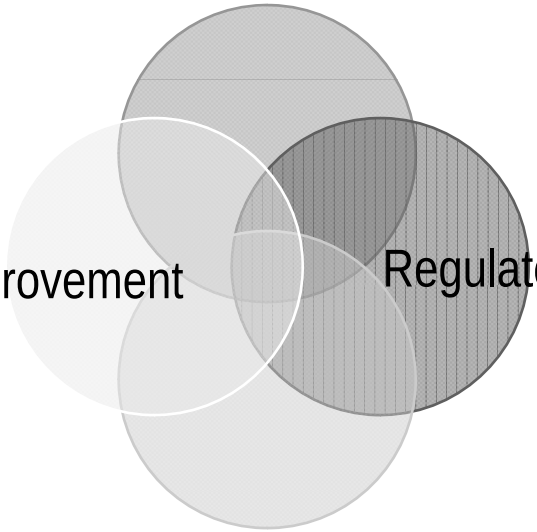
Role of Quality Consultant

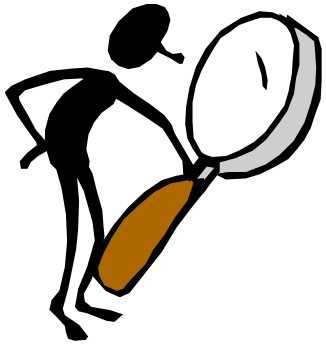
Safety



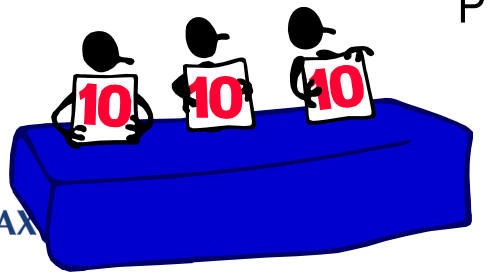
Performance Improvement



Regulatory Readiness



Peer Review



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Role of Quality Consultant - Safety

- Safety Huddle – weekly / daily message
- Safety Coach program
- Safety phone
- Red rules
- DNU abbreviations
- HAM SALAD

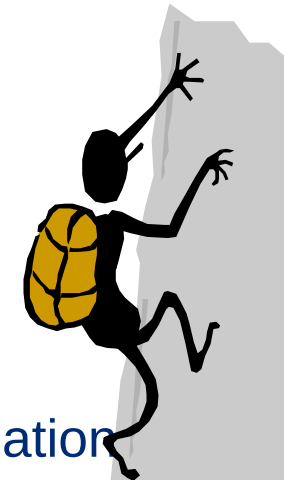
Role of Quality Consultant - Safety

- Rapid Response Team (RRT)
- Environment of Care Tours
- Safety Culture Survey
- Medication Safety Oversight Committee
- Site visits from one Inova facility to another

Role of Quality Consultant - Safety

- Tubing Mis-connection project
- Safety Fair
- Data analysis for trends
- Data mining and display
- Root cause analysis
- Board and Administrative Ownership is KEY

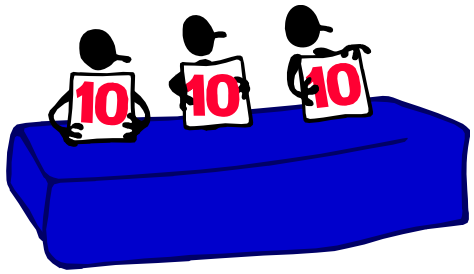
Role of Quality Consultant – Performance Improvement



- LEAN
- PDCA: Plan – Do – Check - Act
- Collaborative Learning Communities
  - 100K Lives Campaign, Sepsis, Flow, Organ Donation
- Team Facilitation
- Bundle Compliance Teams
- Clinical Effectiveness Teams

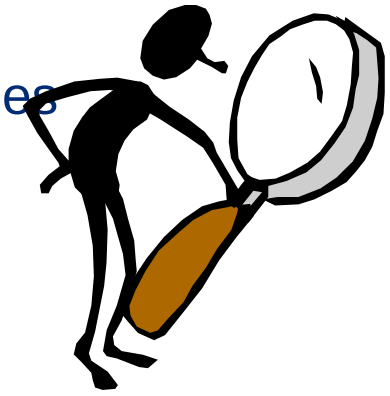
Role of Quality Consultant – Peer Review

- Care Science, Crimson Initiative
- Mortality, Morbidity
- Indicator Development
- Case Finding, Screening, Investigation
- Chart preparation, Data entry, Minutes
- Ongoing Professional Practice Evaluation (OPPE)
- Focused Professional Practice Evaluation (new)
- Focused Review
- Credentialing Report



Role of Quality Consultant – Regulatory Readiness

- **Federal** - CMS (Medicare and Medicaid) can survey announced or unannounced.
- **State** - State surveys hospitals every two years with 48 hours notice; can also survey or investigate complaints unannounced
- **County** - Fire Marshall can survey unannounced
- **The Joint Commission** – Starting in 2006, TJC surveys became unannounced. Survey every three years; also conduct random unannounced surveys.
- **Other** - There are a variety of other regulatory bodies that also conduct surveys - CARF, NRC, CAP, etc.



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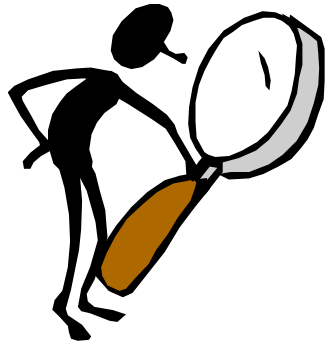
Role of Quality Consultant – Regulatory Readiness

- Periodic Performance Reports (PPR)
- Strategic Surveillance System (S3)
- Outcomes Data: Core Measures, SCIP, Vermont – Oxford, NDNQI
- Complaint Investigations
- Mock Surveys (Dress rehearsal)
- Gap analysis



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Role of Quality Consultant – Challenges

- Paper Records
- Changing regulatory environment
- “Blue” Rules
- Competing Priorities
- Integrating new technology
- New Stakeholders
- Demanding populations
- Ethical issues – End of Life
- Leadership “buy in”

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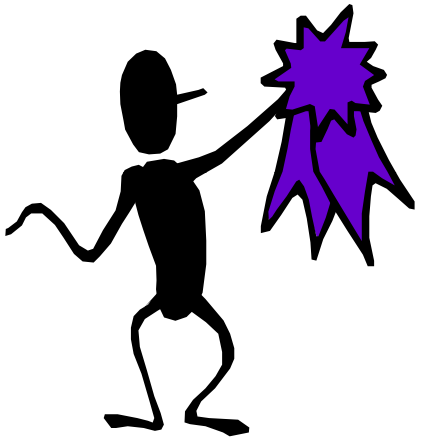
Why is Quality Important to Inova Fairfax Hospital?



- Our Mission: To improve the health of the diverse community that we serve, through excellence in patient care, education and research
- Our Vision: To be the best healthcare system in the world
- Our Core Values:
  - Caring for and about people
  - Innovation
  - Community responsibility

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Inova Fairfax Accomplishments

Health Grades

One of the top 50 hospitals in the United States for the 2nd consecutive year.

Ranked Best in Virginia for Cardiology Services for two years in a row (2009-2010)

Ranked Best in Virginia for Treatment of Stroke for three years in a row (2008-2010)

Recipient of HealthGrades' Stroke Care Excellence Award for five years in a row (2006-2010)

Ranked Best in Virginia for GI Medical Treatment for two years in a row (2009-2010)

Recipient of HealthGrades' Gastrointestinal Care Excellence Award for six years in a row (2005-2010)

Inova Fairfax Accomplishments

- American Nurses Credentialing Center
  - Magnet Status since 1997
  - First Magnet Hospital in DC region,
  - One of 102 nationally

- US News and World Report
  - Top 50 hospitals for GYN, Urology, Heart and Heart Surgery

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Inova Fairfax Accomplishments

- Health and Human Services
  - Medal of Honor for Organ Donation
- Joint Commission Disease Specific Certification
  - Primary Stroke Center
  - VAD (Ventricular Assist Device)
  - Transplant
- American College of Surgeons
  - Level 1 Regional Trauma Center
- Working Mother Magazine
  - Top 100 Employers

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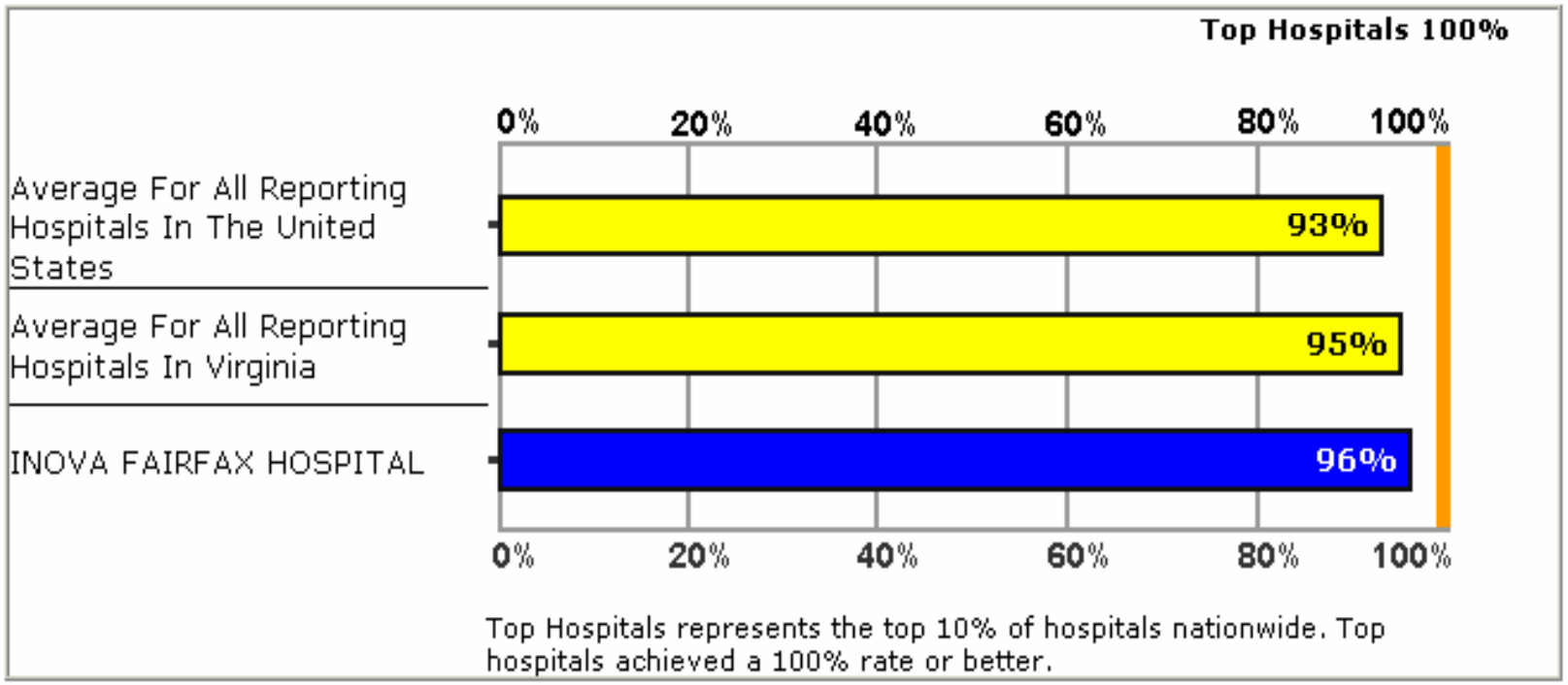
www.hospitalcompare.hhs.gov

Graph 1 of 8

Hide **Percent of Heart Attack Patients Given Aspirin at Arrival**

The rates displayed in this graph are from data reported for discharges July 2006 through June 2007.



Data prepared for:

INOVA FAIRFAX HOSPITAL

HOSPITAL COMPARE - HCAHPS

September 2009 release

HCAHPS - Discharges from January 2008 to December 2008		Your Hospital	National				
		Score	Average	25th PCTL	Median	75th PCTL	Total N
Would patients recommend the hospital to friends and family?	**YES, patients would definitely recommend the hospital**	**70%**	**68%**	**61%**	**68%**	**75%**	**3,765**
	YES, patients would probably recommend the hospital	25%	26%	21%	26%	32%	3,765
	NO, patients would not recommend the hospital (they probably would not or definitely would not recommend it)	5%	6%	3%	5%	7%	3,765
Number of Completed Surveys		300 or More					

Quality from the Patient's Perspective

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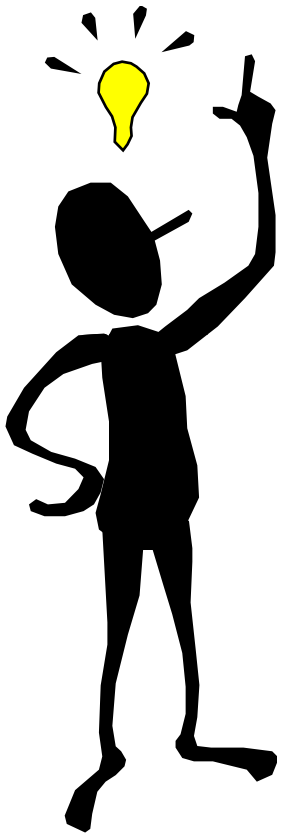
Questions



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