The Quality Perspective In a Large Healthcare System:
Viewing the Forest and Each Tree

Anne Greer MSN RN
Nursing Quality Analyst

Greenville Hospital System University Medical Center
Greenville South Carolina

Objectives

- Describe integration of quality data trends into useful multilevel measurement tools

- Identify how unit based quality teams led by physicians and nurse managers can impact patient outcomes

Greenville Hospital System

- Integrated Healthcare System
- 5 Campuses with 8 Facilities + Home Health/DME
  - ➢ Large Tertiary Medical Center
  - ➢ Behavioral Health Hospital (inpatient & outpatient)
  - ➢ Acute Rehabilitation Hospital
  - ➢ Two Community satellite hospitals
  - ➢ Long Term Acute Care Hospital
  - ➢ Short Stay Specialty Surgical Hospital & O P Surgery Center
  - ➢ Skilled long term care nursing center/ Cottages of Brushy Creek
  - ➢ Home Health & DME
  - ➢ Multiple clinics and Physician Practices
  - ➢ 2812 Registered Nurses
  - ➢ 1050 Physicians on Medical Staff
  - ➢ Multiple university medical group physician practices & clinics

Strategic Planning

Levels of Views

➢Board level- CEO- system

➢CNO/ COO

➢Facility- President/CNO/Director

➢(Multi)Service Focus- Director

➢Unit level leadership- Manager

➢Unit councils – staff

In the beginning....................

- Bombardment of data for the nurse manager!!

- Difficult to interpret & prioritize volumes of data
- Aggregate-level data=No ownership of issue
  "not my problem...Data does not reflect what happens on my unit"
- Lack of integration between unit level performance and system quality initiatives
- Need for unit leaders and bedside staff to better understand how each unit contributes to the outcomes of the organization

Finding specific trees in the forest

- Initial focus ~largest facility ---get scorecards out there for review and use
  - On main campus (3 facilities)-39 scorecards w/ few combined scorecards
  - System - 55
- As scorecards became popular tools for trending….. Began reporting off the graphs to demonstrate quality improvement
- Requests from other campuses and units ..

  "how can I get a scorecard for my unit"

How

- A Difficult Extract-
  - Data in some many places/departments/levels
  - Different databases

- Data Overload

Getting the right DATA!

- Silos of ownership
- Data in a useable way
- Data integrity
- Identifying benchmarks for specialty quality indicators can be difficult
  - "apples to apples"
- Internal databases; different servers; different formats; shared folders; how to access

Nursing Quality Analyst

Creation of tools for
UNIT LEVEL measurement & trending

- Interpret & prioritize w/ benchmarks
- Provide unit-specific data to stimulate ownership and actions for improvement
- Integrate unit-level performance with system quality initiatives
- Refocus unit leadership and bedside staff on quality improvement and patient outcomes

GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER
ghs.org

Selecting metrics for unit level - *the roots*

- *High impact*--- unit based ability to improve & nursing sensitive with focus on patient outcome
- *Requirement* by accrediting body and unit underperforming
- Involved with *public reporting* (*but nurse sensitive*)
- Has *benchmark* at state, regional or national level
- If on nurse manager's annual performance tool then ~~~consider as **high priority** focus
- Is there level of **accountability** for outcomes

Data must be available and integrity maintained

Data Owners

- Key allies in the process
- Stakeholders for data integrity
- Need to know how collected
- How to gain access
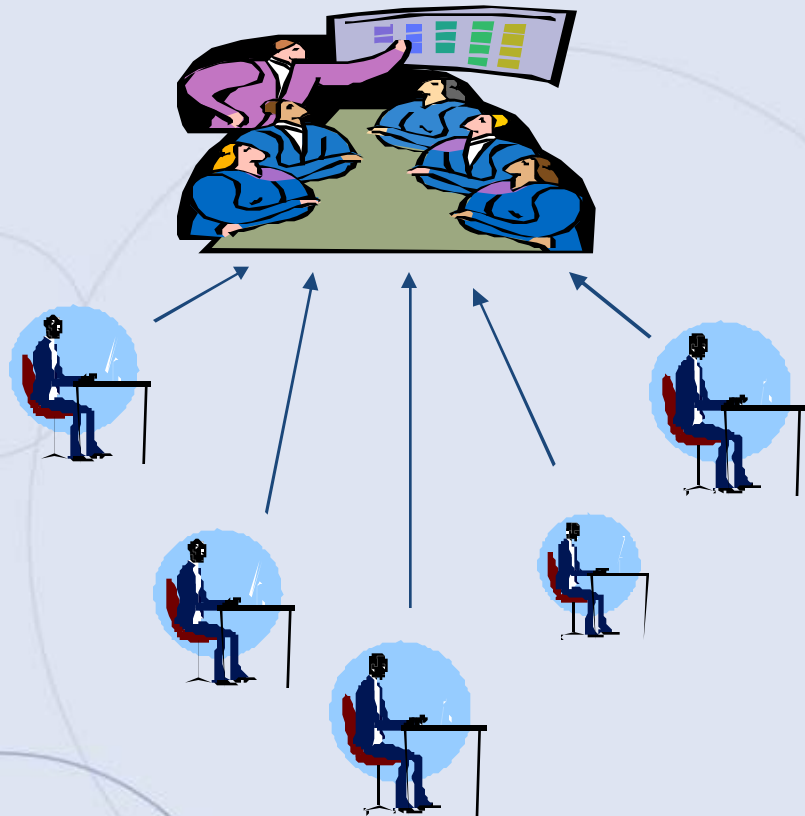
Forest begins with each sapling

Unit Quality Scorecard: Sample Unit Name/ Unit Number

Monthly Indicators	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
UA CLABSI Rate	5.49	5.67	1.25	4.23	1.56	2.76	1.25	1.59	1.48	1.25	1.05	0.50	2.03	0.00	0.00	0.00	0.00	2.10	1.00	0.00	0.00	0.00	2.10	1.00
External Benchmark	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	1.60	1.60	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
UA CAUTI Rate	4.56	2.03	2.69	2.05	1.96	1.60	2.65	1.25	2.03	0.50	1.56	2.00	1.56	1.50	0.90	0.20	2.65	0.50	1.25	0.90	0.20	2.65	0.50	1.25
External Benchmark	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32
UA MRSA Inf Rate	4.56	2.03	2.69	2.05	1.96	1.60	2.65	1.25	2.03	0.50	1.56	2.00	1.56	1.50	0.90	0.20	0.50	1.56	2.00	0.90	0.20	0.50	1.56	2.00
External Benchmark	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68
Unit Hand Hygiene										68.0%	73.0%	68.0%	79.3%	82.2%	79.3%	68.0%	82.2%	79.3%	82.2%	85.3%	92.0%	68.0%	92.0%	98.0%
GHS FY Target										70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	80%	80%	80%
Urinary Catheter Utilization Ratio	0.26	0.29	0.26	0.29	0.22	0.28	0.20	0.26	0.26	0.29	0.24	0.29	0.26	0.22	0.19	0.20	0.23	0.20	0.18	0.19	0.20	0.23	0.20	0.18
External Benchmark	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.23	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21	0.21
Optional Outcome indicator	0.00	10.87	0.50	3.05				7.20	00		5.20	0.00	1.50	0.00	0.20	0.50	1.60	0.10	0.00	0.20	0.50	1.60	0.10	
External Benchmark (required)	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35	2.35

Quarterly Indicators	2nd Q 2008	3rd Q 2008	4th Q 2008	1st Q 2009	2nd Q 2009	3rd Q 2009	4th Q 2009	1st Q 2010
Pt Fall Rate	5.73	4.00	4.79	5.67	2.22	2.12	5.22	4.03
External Benchmark	4.26	4.35	4.50	4.62	4.56	4.09	4.23	3.98
Restraint Rate	4.76	0.90	0.50	0.00	0.20	0.40	0.30	0.20
External Benchmark	1.02	1.01	1.56	1.93	1.67	1.89	1.75	1.98
UA Pressure Ulcer Rate	9.52	0.00	8.00	4.00	0.00	4.55	8.70	6.71
External Benchmark	2.41	3.65	3.54	3.98	3.12	2.98	2.78	3.01

Scorecard Key

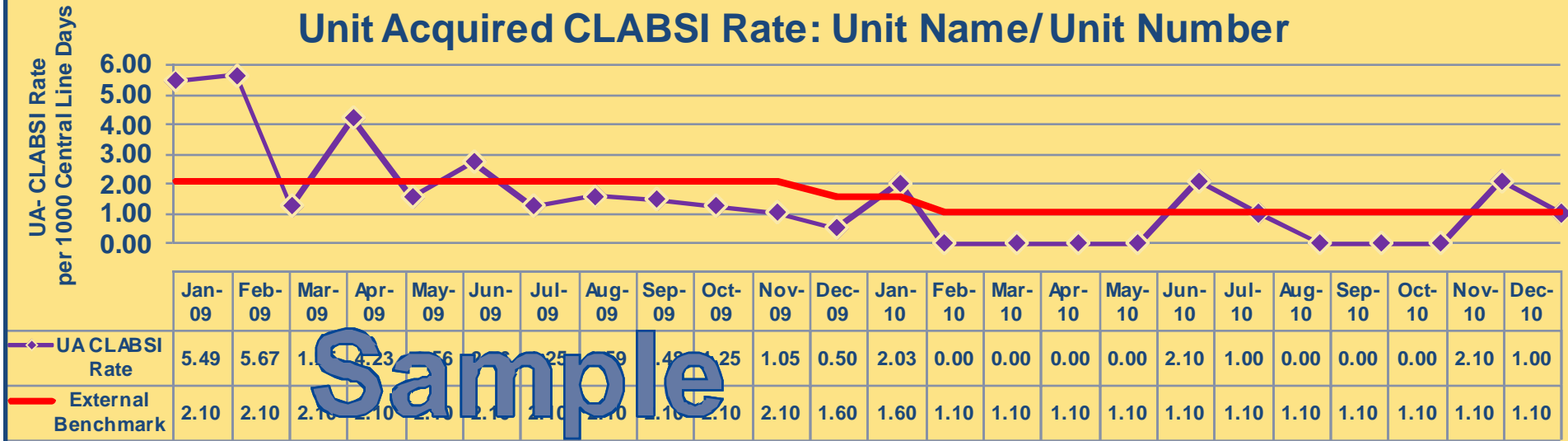|	
green background	Magnet Quality Indicator
peach background	Unit-Specific Quality Indicator
yellow background	Externally Benchmarked Target
grey background	No data received, or insufficient data
Green Font	Target achieved
Red Font	Target not achieved

Effective (start month) /2010:

In the event of two or more consecutive red data points, Unit Medical Director/Nurse Manager Team is to develop and submit action plan to DON & Drs Jones and Smith electronically within 30 days of receipt of scorecard.
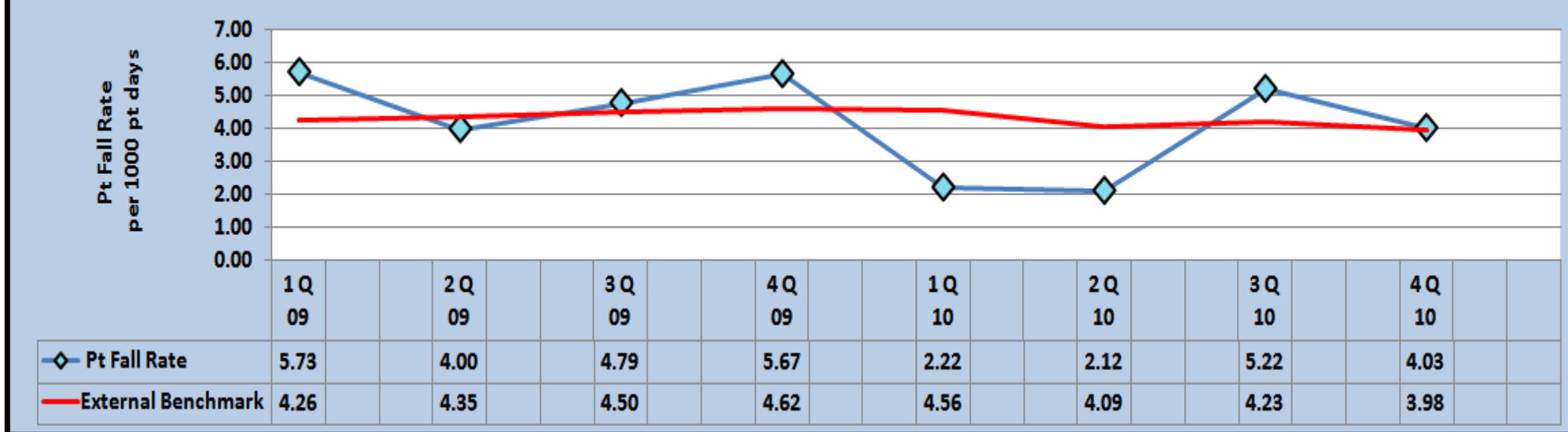
Graphics: Unit-Level Scorecard
Example- graph for each indicator

GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER

Unit Acquired CLABSI Rate: Unit Name/ Unit Number

UA- CLABSI Rate per 1000 Central Line Days

Sample

	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
UA CLABSI Rate	5.49	5.67	1.5	4.23	.56	2.5	1.25	1.59	1.48	1.25	1.05	0.50	2.03	0.00	0.00	0.00	0.00	2.10	1.00	0.00	0.00	0.00	2.10	1.00
External Benchmark	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	2.10	1.60	1.60	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10

Pt Fall Rate: Unit Name/Unit Number

Pt Fall Rate per 1000 pt days

	1Q 09	2Q 09	3Q 09	4Q 09	1Q 10	2Q 10	3Q 10	4Q 10
Pt Fall Rate	5.73	4.00	4.79	5.67	2.22	2.12	5.22	4.03
External Benchmark	4.26	4.35	4.50	4.62	4.56	4.09	4.23	3.98

Facility Level Data

Pt Satisfaction with Pain Control
Hospital Level Example
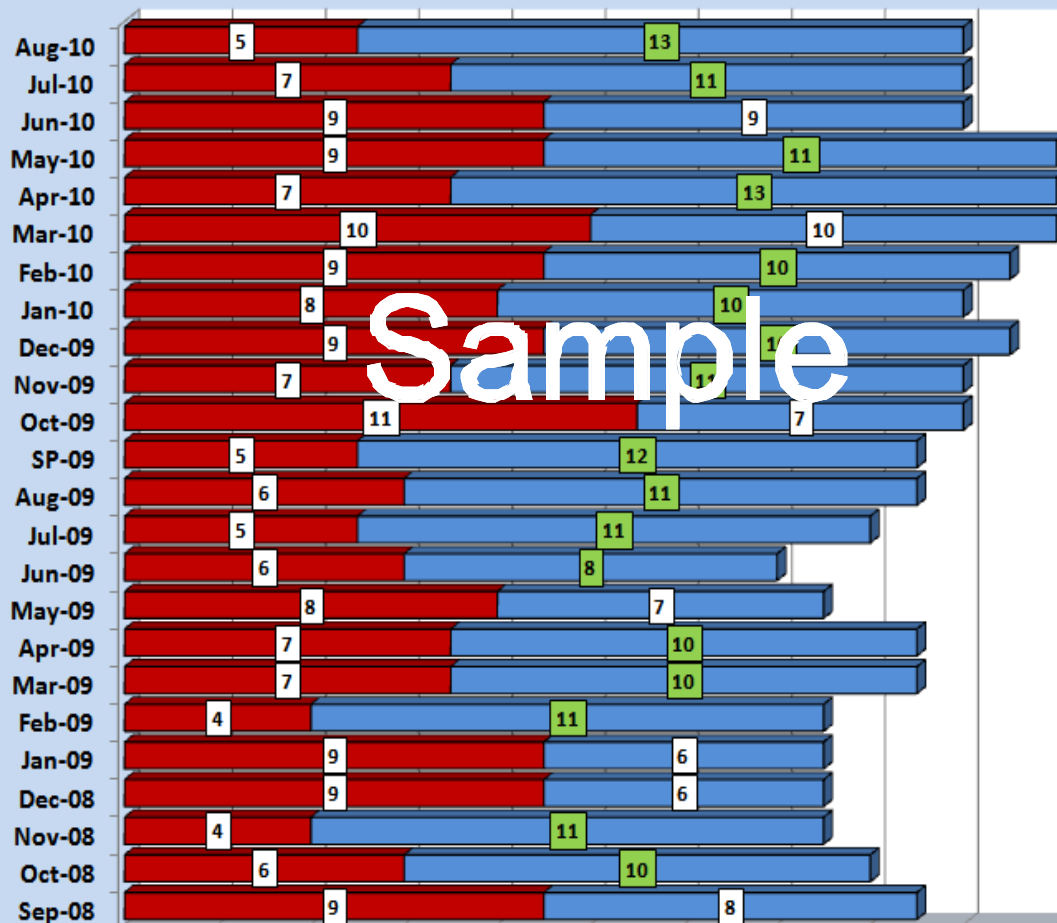
Legend:
- Number of units scoring at or below the mean of the national benchmark (red)
- Number of units scoring above the mean of the national benchmark (blue)

Analysis:

Months in which the majority of units are "top performers" are indicated in green.

The majority of units have outperformed the mean of the national database for 17 of the past 24 months.

Organizational Level Data

Organizational level Reporting
How to track across time

Patient Falls: GHS

Calendar Year Quarters

Quarter	Red (# with More Pt Falls)	Blue (# with fewer Pt Falls)
2Q 10	14	17
1Q 10	13	18
4Q 09	13	
3Q 09	12	17
2Q 09	10	18
1Q 09	15	13
4Q 08	10	18
3Q 08	11	14
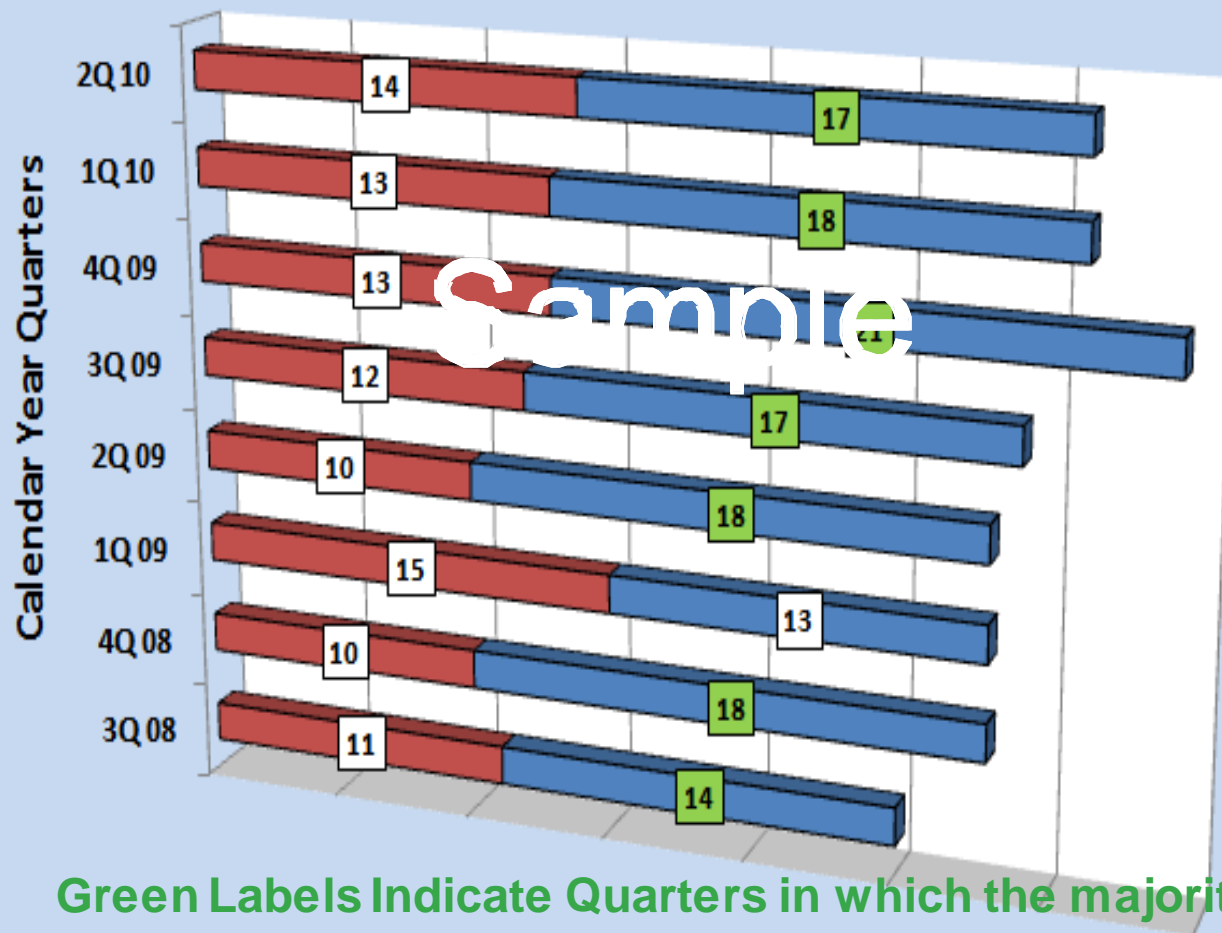
Sample

Legend:
- # of GHS Units with More Pt Falls than the national comparative mean
- # of GHS Units with fewer Pt Falls than the national comparative mean

Green Labels Indicate Quarters in which the majority of Units were "top half performers".

Example-Board Level *DASHBOARD*

Quality Dashboard

CY 2008	1Q 09	2Q 09	3Q 09	4Q 09	1Q 10	2Q 10	QUALITY MEASURE
🟩	🟥	🟩	🟥	🟩	🟩	🟩	CMS All Care Measures
🟩	🟩	🟩	🟩	🟩	🟩	🟩	Mortality Rate
🟩	🟩	🟥					Readmission Rate within 30 days
🟩	🟩	🟩	🟩	🟩	🟩	🟩	National Pt Safety Goals
🟩		🟩				🟩	AHRQ Culture of Safety Survey (annual)
🟥	🟩	🟥	🟩	🟩	🟩	🟩	Events: Inpatient Falls
⬜	🟥	🟩	🟩	🟩	🟩	🟩	Hand Hygiene
🟩	🟩	🟩	🟩	🟩	🟩	🟩	Surgical Site Infections
🟩	🟩	🟩	🟩	🟩	🟩	🟩	Central-Line Blood Stream Infections
🟩	🟩	🟩	🟩	🟩	🟩	🟩	Ventilator-Associated Pneumonia

sample

MD RN Teams

- Each unit has an assigned medical director MD
  - Job description for Unit Medical Director
  - Supported by medical Vice Chair
- Manager / Medical Director Model
  - Joint **authority and accountability** for the unit.
  - **Empowered** to manage all aspects of the operations of the unit or clinical service line
  - **Drive performance** in regards to quality, patient safety, and efficiency
  - **Key users of information** and support resources of the organization.

Specialty area needs

D2B TIME <90 Minutes: Percent of CPC Patients
YTD 2009
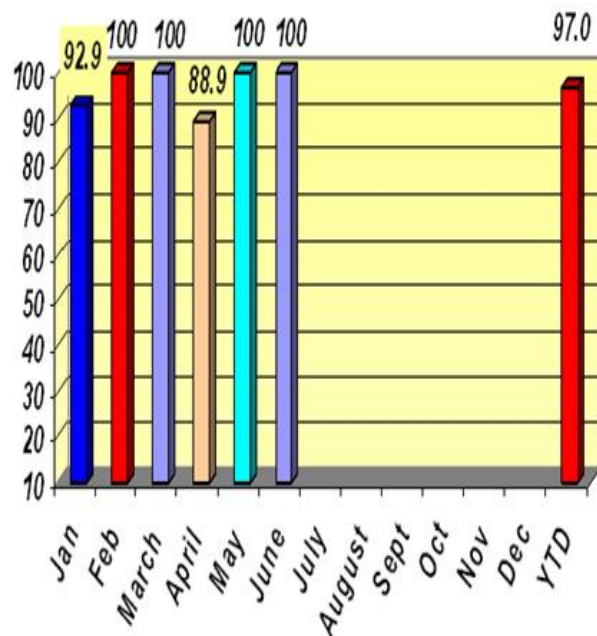
MD/ RN teams identify their specific quality indicators/need for monitoring

CCU- STEMI patient example

- Coordinate data monitoring for all stakeholders in the process

- CCU– ER at main hospital– ERs at satellite hospitals

- Focus on teams and how their outcomes contribute to the whole

Example of Outcome Of VAP Initiative of MD/ RN team in One Critical Care Unit

GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER
ghs.org

Ventilator Acquired Pneumonia Rate

	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10
VAP Rate	18.78	0.00	6.99	5.35	10.71	6.29	6.33	0.00	5.18	0.00	4.98	5.32	0.00	0.00	0.00	5.92	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHSN Mean	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9

VAP Rate per 1000 vent days

Dissemination of Data & Outcomes

- **Internal**
  - Board
  - CNO
  - Med Exec QI
  - Quality committee
  - MD RN teams
  - Nursing PI council
  - Unit councils
- Annual nursing report
- Fun events---
  - *FISH Festival*

- **External**
  - Organizational annual report
  - TJC; CMS
  - State/ Government regulatory
  - Public reporting & community
  - Conferences
  - Publications
  - Quality Documents
    - i.e. Magnet

Challenges

SO NEAR,

Lessons learned

- Use visual diagram/graphs for dissemination
- MDs want to see actual data behind the graphs
- Value of MD champions ~ key to impacting patient outcomes; accountability and focus
- Building working relationship of the NM and MD takes time, role modeling
- Use staff Unit councils ~ disseminate data, make process changes, to increase awareness of disconnects
- Education of stakeholders … keep focus on patient outcomes- *get back to the "roots"*
- Use of MD VICE CHAIR for quality

Where are we today?

- Use of web based programs for shared access
- Use of organizations' webpage
- Increased engagement of MD leadership in <u>standardizing and prioritizing</u>
- Transparency focus as accountable care
- Monitoring requirements for external reporting and changes annually
- Focused unit level to best practice with expected external reporting,
- Integration with management performance evaluations

Questions?