

Structuring a Healthcare Performance Improvement Process that Results in Incentive Payments

PATRICIA DONOVAN: This is Patricia Donovan for the Healthcare Intelligence Network. Today I'm speaking with Liz Popwell, Vice President of Systems Management at Cleveland County Healthcare System. Liz is presenting at HIN's audio conference, on "Structuring a Healthcare Performance Improvement Process that Results in Incentive Payments". Thanks for joining me today Liz.

LIZ POPWELL, VICE PRESIDENT OF SYSTEMS MANAGEMENT AT CLEVELAND COUNTY HEALTHCARE SYSTEM: I'm glad to be here. Thank you.

PATRICIA DONOVAN: First of all, in the case study that's available from the CRMC website you attribute much of CRMC's quality improvements to the use of real time chart monitoring tools. Can you provide a few examples of the data that these tools can provide and how a physician or a nurse can use the data to improve a patients experience and outcome?

LIZ POPWELL: I would be happy to. One of the tools that we have is a data analysis tool that allows us to look at each indicator of care that is provided by patient and we're allowed to put that data in there real time. So when our nurses are running concurrent chart review, they actually have the ability to collect the data and provide reports to leadership physicians whomever needs that data on a real time basis. Most of that data is available to us upon discharge of the patient. So if I were in the hospital last week and I was discharged Monday of this week then my data would be available for viewing and reporting on that Monday. And what we have been able to do with that data is actually pull reports out for education purposes to identify where we had processes breakdowns or potential problems where we might have repeat occurrences where we were missing key indicators for our patients. And that data has actually been sent back to our nursing leaders so that they can help use that for education purposes or for accountability purposes if

necessary.

In addition to that we also have physician reports that come out of the system that give the physicians data on all of their patients. They have aggregate numbers and then we can drill in to that and show them by patient if they prefer what data was missing, not appropriate, or what data showed that we had met the indicators for those patients and that's all done by disease process. So those reports have been very powerful and we've used more of the nursing reports than the physician reports because that's where our biggest challenge has been with some of our process improvement.

PATRICIA DONOVAN: I see. Thank you Liz. This same case study notes that CRMC readmission rates have dropped 37%. Would you say that this is strictly due to most of the patients receiving proper discharge instructions now or are you looking at different aspects of care transitions for the patients that are most likely to be readmitted?

LIZ POPWELL: We are actually looking at more than just the discharge instructions, although we recognize that's a very important part of congestive heart failure patient care. A lot of those patients especially the newly diagnosed patients have to make some lifestyle changes. So we do emphasize the importance of discharge instructions and we actually start that process as soon as the patient is diagnosed with congestive heart failure. We call a CHS survival kit and the nursing staff actually start to give that to the patients throughout their stay and talk to them about their lifestyle changes, weighing daily, medications, all of those important things, nutrition. We also look at what we call perfect process. We actually analyze all of our patients for the appropriate care that they need. Each patient is unique and has different needs and although the core measures and the HQID project focuses on the best practice. We also focus not just this process indicators, but did each patient get what they

needed? If I were a smoker and needed smoking cessation counseling did I get that counseling in addition to my medications and my discharge instructions? So we really have taken a holistic approach to the patients and we actually have additional data that we look at for that.

And the additional piece is we actually have an outpatient care solutions department at the hospital if you will. It's really a case management program and basically what they do is they look at our high risk readmission patients for congestive heart failure and we have funded that program so that they go out into the home and help patients with their dietary restrictions, with their discharge instruction needs. We've found that a lot of our readmissions have been reduced from focusing on the holistic approach that patient what their needs are. And for the high risk population really making sure that if there is a low income person and they cannot afford fresh fruits and vegetables, we look for resources in the community to help them, so that they can eat a healthy diet and maintain the discharge instructions as best we can to keep them in the home.

PATRICIA DONOVAN: Thank you Liz. It really does sound like a patient centered approach that you're taking. And as you enter year three of this demonstration project on which areas will you be focusing and what are the challenges of sustaining the processes you've implemented?

LIZ POPWELL: As we enter year three we're actually looking at the SCIP initiative, the Surgical Care Improvement Project, and our biggest challenge really has been hardwiring processes. We have had concurrent chart reviewers who have gone up to the floors every day to look at patient needs and it seems like every time we get a new batch of nursing students out of school, new graduate students, we have to re-teach them the core measures to those folks. So it's been a constant challenge to keep up with educating folks on the appropriate processes and why these things

are so important for our patients. And that's been across all of the HQID measures, congestive heart failure, AMI, pneumonia, we have really struggled with how do we keep everybody, especially the new staff coming in well educated on the processes they're supposed to follow. So we have had nurses, we call them concurrent chart reviewers who come behind and they coach staff on an ongoing basis, everyday they're on the floor making sure that patients are getting what they need. And then they're going back into educating nursing and trying to help nursing hardwire those processes.

But as we add new processes our challenge is going to be we want to hardwire processes without having to contribute to focus on those things and adding new things, like the SCIP project which obviously adds new processes we need to look at and additional challenges. So as we have those additional challenges just resource needs to keep up with that has been an ongoing discussion for us.

PATRICIA DONOVAN: Well those are all the questions that I have today Liz. I thank you very much for being with me. And we're looking forward to hearing more from you during the audio conference.

LIZ POPWELL: Great. I'm looking forward to it as well.

PATRICIA DONOVAN: To register or get more information about this conference please call 1-888-446-3530. This is Patricia Donovan for the Healthcare Intelligence Network.

