Advancing Value, Safety and Care For ZSFG’s Patients Through Value Based Programs

Troy Williams, RN, MSN, Chief Quality Officer
Title: Advancing Value, Safety and Care for SFMG's Patients Through Value Based Programs

I. BACKGROUND

The national landscape for payment is shifting to support value based programs, which provide reimbursements based on quality and cost of care provided to patients. Starting in July 2017, the San Francisco Health Network (SFHN), along with all California Public Hospitals will be participating in the Quality Incentive Program (QIP), which is part of the Medicaid Managed Care Rule. QIP is a year after year performance program tied to approximately $20 million to $60 million of funds. These funds replace supplemental payments that we received to be in alignment with the Medicaid Managed Care Rule.

In the last decade, SFMG and SFHN witnessed the progression of value based programs. By 2018, SFHN will have received $80 million from these programs, compared to the $80 million received prior to 2009. SFMG has participated in multiple Value Based Programs (VBP). Given the changing landscape, SFHN leadership has shifted the strategic Safety Goals from reducing four patient harm events (i.e., falls with injury, CAUTI, Colon SSI and HAPI) to meeting QIP targets.

II. CURRENT CONDITIONS

From our efforts to reduce patient harm, we learned that we can achieve Quality Improvement (QI) success through the use of A3 thinking, executive oversight and holding all leaders accountable. Despite this progress, there remains no consistent management system across the organization to drive improvement work. With SFMG's participation in QIp and other VBP, the organization has seen the need to further focus on align departmental goals with strategic priorities, such as the implementation of the Daily Management System (DMS) across all SFMG departments/units.

The QIP roadmap will involve three phases: Acquiring Baseline Data, Conducting PI work, and Data Submission.

PHASES
1. Baseline data
2. PI work
3. Reporting

CURRENT CONDITIONS
- Data build and validation time is consuming and is proving to be difficult.
- Operating using very complicated data systems
- Multiple databases and data sources
- QIP was only approved May 2018 by CMS and the SFMG Manual specifications are still being finalized; metric definitions keep changing
- NEWLY FORMED TEAMS: TRIAD MODEL (IS analyst, Analyst, and Subject Matter Experts (SMEs))
- CURRENT PERFORMANCE (BASELINE DATA) TO INFORM QI IS UNKNOWN
- CURRENT BENCHMARKS UNKNOWN
- WE HAVE SLAID UNITS/DEPARTMENTS
- LACK OF ALIGNMENT BETWEEN DEPARTMENTS AND STRATEGIC PRIORITIES
- STAGGERED DMS ROLL OUT ACROSS HOSPITAL.
- MULTIPLE SOURCES OF DATA
- THERE IS USUALLY A SCRAMBLE TO SUBMIT DATA LAST MINUTE, DUE TO THE COMPLEXITY OF OUR DATA SYSTEMS AND RESOURCES

For the first reporting year, we will receive payments for reporting all 12 metrics regardless of our performance on each metric. However, starting in Year 2 of QIP, we will receive payments based on our performance. Targets for each metric are considered met either by meeting the 90th percentile for that metric, or by meeting a 10% gap closure.

Problem Statement (Gap): SFMG will lose $12 million in FY 17-18 if we don’t report all 12 metrics by December 15, 2018 and will continue to lose $12 million/year if we don’t meet QIP targets.

III. GOALS & TARGETS

Year 1: Report all Specialty Care, Inpatient Care and Resource Utilization QIP metrics by December 15, 2018.

Years 2 & onwards: 90% of metrics will meet QIP metric targets for payment year (either by meeting the 90th percentile or reaching a 10% gap closure).

IV. ANALYSIS

ZSF will report on 12 metrics across three out of four domains for QIP: Specialty Care, Inpatient Care, and Resource Utilization.

Primary Care metrics will be covered under the SFHN. This A3 will be nested underneath the ZSF Way Strategic A3.

V. PROPOSED COUNTERMEASURES

<table>
<thead>
<tr>
<th>ROOT CAUSE</th>
<th>IMPACT</th>
<th>EFFORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with EPIC to capture required elements of QIP and facilitate performance reporting.</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Build teams consisting of analysts, data analysts, SME, and clinical informaticist to build and validate data.</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Analyze QIP baseline data and identify PI drivers.</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Create structure to monitor ongoing performance (i.e. monthly dashboards).</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Integrate QIP metrics with departmental drivers Deployment Plan and executive strategies.</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Monitor metric performance via TN scorecard.</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>Incorporate QIP metrics into DMS improvement hurdles and department PIPS reports.</td>
<td>High</td>
<td>Med</td>
</tr>
<tr>
<td>No Standard QI Method</td>
<td>Implement DMS across all units at SFZG.</td>
<td>High</td>
</tr>
<tr>
<td>Create dashboards informing teams of QIP metric progress.</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Communication/Engagement</td>
<td>Develop steering committee to actively engage clinical and administrative leadership in improving QIP driver metrics.</td>
<td>High</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Educate unit leaders regarding deployment of QIP metrics on their units.</td>
<td>High</td>
</tr>
</tbody>
</table>

VI. FOLLOW-UP

<table>
<thead>
<tr>
<th>PLAN</th>
<th>WHO</th>
<th>WHEN</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create triads consisting of an IS Analyst, Data Analyst and Subject Matter Expert (and Clinical Informaticist) for each metric.</td>
<td>Reena Gupta, and Renata</td>
<td>Apr - Jul 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>Share Deployment Plan at Pre-PIPS Coaching sessions with each PIPS department, highlighting applicable QIP metrics.</td>
<td>Will Huynh, Leslie Safler, Nisha Anand</td>
<td>May 2018 Apr – Dec 2018</td>
<td>Completed in progress</td>
</tr>
<tr>
<td>Develop PASTA and Structure for Steering Committee</td>
<td>Troy Williams</td>
<td>Jul 2018</td>
<td>In progress</td>
</tr>
<tr>
<td>Catchball A3 with stakeholders.</td>
<td>Troy Williams</td>
<td>Jul 2018</td>
<td>In progress</td>
</tr>
<tr>
<td>Integrate QIP work into EIPIC Regulatory Quality Reporting Workgroup</td>
<td>Reena Gupta</td>
<td>Sep – Dec 2018</td>
<td>In progress</td>
</tr>
<tr>
<td>Integrate QIP measures into DMS unit scorecards within 3 months of DMS implementation</td>
<td>Leslie Safler</td>
<td>Jul 2018 - Jun 2019</td>
<td>In progress</td>
</tr>
</tbody>
</table>
2017 ACHIEVEMENTS

• Achieved a 48% reduction in patient harm (CAUTI, Colon SSI, Falls with injury, HAPI) from FY 15-16 baseline (164 harm events/year).

• Achieved 63% safe discharge to home rate for CJR patients.
2017 LESSONS LEARNED

• Through a combination of applying A3 thinking, leadership oversight, and holding all parties accountable, we successfully met our Safety goal in FY 17-18.

• No consistent management system across the organization to drive improvement work.

• Focus and alignment of departmental goals with strategic priorities is needed to successfully sustain improvements.
2018 STRATEGIES

Advancing Equity
Improving Value and Patient Outcomes
Ensuring Flow and Access
Optimizing Care Experience
Optimizing Workforce Care & Development
The ZSFG Way
Building for the Future
Implementing an enterprise-wide Electronic Health Record

The ZSFG Way
Advancing Equity
Advancing Value, Safety and Care For ZSFG’s Patients Through Value Based Programs
Ensuring Flow and Access
Optimizing Care Experience
Financial Stewardship
Building for the Future
Implementing an enterprise-wide Electronic Health Record
BACKGROUND

Shifting Landscape:

- Payment structures have been shifting to support value based programs.
- By 2018, the SFHN will have received >$80 million from all value based programs.

Quality Incentive Program (QIP):

- QIP began in 2017. Year 1 is FY 17-18.
- QIP is tied to approximately $20 million/year of funds across the SFHN.
- These funds replace supplemental payments that we received through the Managed Care Rule.
- QIP is a year after year incentive program.
CURRENT CONDITIONS

• Shifting the strategic Safety goal from reducing total harm events to meeting QIP targets.

  - FY 2015-2016
    True North Strategic A3: Reduce Patient Harm
    Status Sheets and A3 Development
    5 Model Cells
    Inpatient Hospital Move
    Saw a 35% increase in harm events

  - FY 2016-2017
    True North Strategic A3: Reduce Patient Harm
    Focused improvement efforts from 9 to 4 harm metrics (i.e. falls, HAPI, CAUTI, Colon SSI)
    Increased leadership involvement through Steering Committee
    A3 Improvement Framework
    5 Model Cells
    Saw a 32% reduction in harm events

  - FY 2018-2019
    Operational A3 under ZSFG Way Strategic A3
    Shift focus to meeting value based program targets: QIP & PRIME
    Continued leadership involvement through Steering Committee
    A3 Improvement Framework
    Align with DMS Spread
    EPIC Implementation Planning

• The Advancing Value, Safety and Care to ZSFG’s Patients Through Value Based Programs A3 will be nested underneath the ZSFG Way Strategic A3.
PROBLEM STATEMENT

• ZSFG will lose $12* million in FY 17-18 if we don’t report all 12 metrics by December 15, 2018, and will continue to lose $12 million/year if we don’t meet QIP targets.

*Note: ZSFG is responsible for 12 QIP metrics, each tied to $1 million dollars/year.
# TARGET AND GOALS

<table>
<thead>
<tr>
<th>Year 1 (FY 17-18)</th>
<th>Report all Specialty Care, Inpatient Care and Resource Utilization QIP metrics by December 15, 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years 2 &amp; onwards</td>
<td>90% of metrics will meet QIP metric targets for payment year (either by meeting the 90\textsuperscript{th} percentile or meeting a 10% gap closure).</td>
</tr>
</tbody>
</table>
## COUNTERMEASURES

<table>
<thead>
<tr>
<th>Categories</th>
<th>Proposed Countermeasure</th>
<th>Completion Date</th>
<th>Status Update</th>
</tr>
</thead>
</table>
| **Data**            | • Work with EPIC to capture required elements of QIP and facilitate performance reporting.  
• Build teams consisting of IS analysts, data analysts, SME, and clinical informaticist to build and validate data.  
• Analyze QIP baseline data and identify PI drivers.  
• Create structure to monitor ongoing performance (i.e. monthly dashboards).                                                                 | June – Aug 2018                  | In progress   |
|                     |                                                                                                                                                                                                                         | Apr – Dec 2018                   | In progress   |
|                     |                                                                                                                                                                                                                         | Dec 2018                         | Not Started   |
|                     |                                                                                                                                                                                                                         | Jan 2018 – Mar 2019              | Not Started   |
| **Alignment**       | • Integrate QIP metrics with departmental drivers Deployment Plan and executive strategies  
• Monitor metric performance via TN scorecard.  
• Incorporate QIP metrics into DMS improvement huddles and department PIPS reports.                                                                        | Jan – Mar 2018                   | Completed     |
|                     |                                                                                                                                                                                                                         | Mar – Dec 2018                   | In progress   |
| **No Standard QI Method** | • Implement DMS across all units at ZSFG.  
• Create dashboards informing teams of QIP metric progress.                                                                                                   | Mar – Dec 2018                   | In progress   |
|                     |                                                                                                                                                                                                                         | Jan 2018 – Mar 2019              | Not Started   |
| **Communication/Engagement** | • Develop steering committee to actively engage clinical and administrative leadership in improving QIP driver metrics.                                                                                           | Dec 2018                         | Not Started   |
| **Knowledge**       | • Educate unit leaders regarding deployment of QIP metrics on their units.                                                                                                                                            | Mar – Dec 2018                   | In progress   |
2018 ACHIEVEMENTS

• Collaborated with IS, QM and Clinical Subject Matter Experts to create a process to identify, develop and validate QIP Baseline data.
• Integrating QIP metrics into EPIC reporting workflows.
• Integrating QIP metrics into DMS roll out and PIPS reports.
• Educated unit leaders regarding QIP metrics that affect their units.
• We have learned how truly complicated our data systems are.
NEXT STEPS

• Determine baseline data for each metric.
• Share deployment plan with department leaders through PIPS.
• Develop structure for Steering Committee.
• Catchball A3 with key stakeholders.
• Integrate QIP Measures into DMS unit scorecards within 3 months of DMS implementation.
• Integrate QIP work with EPIC Regulatory Quality Reporting Workgroup