Quality and Performance Improvement

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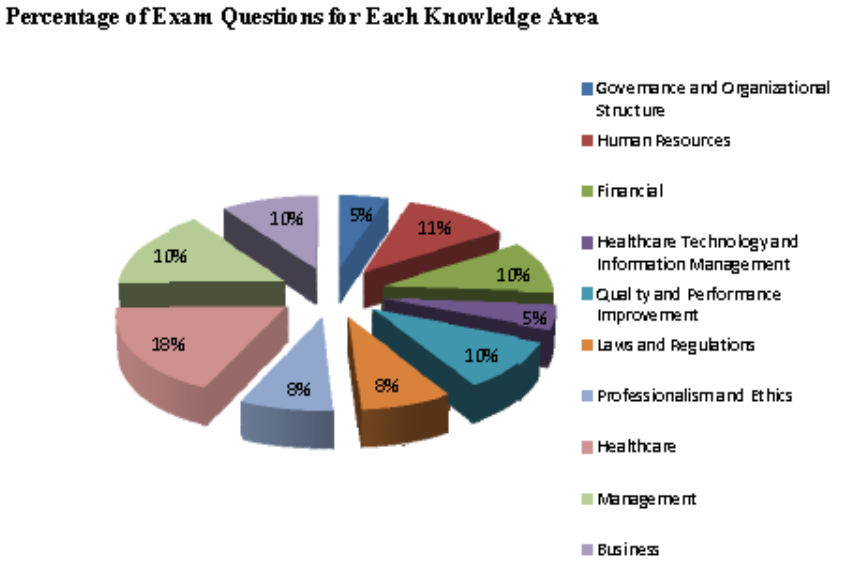
Quality/ Performance Improvement Topic



- **20 Questions, 10% of the Exam**

Are you familiar with benchmarking techniques? Do you have knowledge of risk management principles and programs?

- Knowledge of benchmarking techniques
- Knowledge of medical staff peer review
- Knowledge of risk management principles and programs (e.g., insurance, education, safety, injury management, patient complaint, patient and staff security)
- Knowledge of performance and process improvement
- Knowledge of customer satisfaction principles and tools
- Knowledge of clinical methodologies (e.g., clinical pathways, evidence-based medicine, population health, pay for performance)
- Knowledge of utilization review
- Knowledge of national quality initiatives including patient safety

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Introduction of Faculty/ Presenter

Michelle Adzhemyan, MHA, FACHE

Director – Strategy, Acceleration, & Care Transformation

The Southeast Permanente Medical Group (TSPMG)

- Has spent career working with hospital departments and medical groups to make improvements to patient throughput and satisfaction through application of Lean, Six Sigma, and Innovation tools
- Prior to move to Georgia in 2016, worked for a number of large health care systems in California, including Dignity Health, Providence Health & Services, and Sutter Health
- Received her FACHE in 2013 and her Black Belt Certification in 2010
- Received her Master in Healthcare Administration from the University of and Bachelor Degrees in Psychology and Biology from St. Olaf College
- Has been teaching the Quality and Performance Improvement BOG content to FACHE students in Southern California & Georgia for 5+ years

Today's Agenda

- The Quality Definition
- Quality Improvement
  - Foundation
  - Evolution
  - Types
  - Lean
  - PDCA (Shewhart cycle or Deming Wheel)
  - Value vs. Waste
- Process Improvement Toolkit
- Risk, Regulation & Reporting
- Medical Staff
- Quality and Reimbursement
- Review – 20 Practice Exam Questions

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Culture of Performance Improvement

"What determines how great a healthcare organization will become is how well its leadership system creates a culture of excellence and safety, improves the enterprise system and effectively implements best practices."

"Change Healthcare Organizations from Good to Great"
American Society for Quality 11/2005

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The Quality Definition

In Crossing the Quality Chasm, the Institute of Medicine (IOM) provided a six-part definition of health care quality that some view as the emerging standard.

According to the IOM, health care should be:

1. **Safe** – avoiding injuries to patients from the care that is intended to help them;
2. **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively);
3. **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
4. **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care;
5. **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy; and
6. **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status

Crossing the Quality Chasm, Institute of Medicine, 2001

The Quality Improvement Definition

- Quality Improvement (QI) is a term used to describe a body of knowledge, which consists of the processes and tools needed to continuously improve quality of services and products within organizations.
  - QI techniques and practices have become known to the business world under many different names (CQI - continuous quality improvement, TQM - total quality management, Six Sigma, etc.) but are all built on the same foundation of **customer requirements, statistical measurement, top down support and employee participation**.

- Very simply, **Quality Improvement strives to reduce (if not eliminate) and prevent defects in the flow of work that will decrease costs, enhance the work environment, reduce errors, and improve results in the form of products, services and outcomes**.

Foundation of Quality Improvement

All QI approaches share a common base of knowledge and principles despite some differences in technique or vocabulary.

Process–Oriented Thinking

- **Continuous Quality Improvement (CQI): The reiterative process of improving stems from a philosophy that suggests quality is not something attained, but rather continually sought. The status quo is not sufficient.**

- **There is an interconnectivity of processes and systems; as one part of the system is improved, the relationship or functioning between parts of the system can also be improved as a result.**

- **Better decisions are made when they are:**
  - **Based on data, with proper analysis (not based on intuition/subjectivity)**
  - **Empower stakeholders/staff by including them in the decision-making process, without fear.**
  - **Managers relinquish historic unilateral decision-making**

- **The Process Improvement toolkit can be used to improve the measurement, analysis and reliability of data.**

Foundation of Quality Improvement

All QI approaches share a common base of knowledge and principles despite some differences in technique or vocabulary.

Customer Requirements

- There is a customer and a supplier in every step of every process both internally and externally.

Process

- All work, no matter how simple, is part of a process that can be defined and mapped, step-by-step.

Continuous

- QI is a continuous cycle that requires the discipline to apply the techniques over and over. Steps toward the desired goal are measured, monitored and adjusted, then re-measured to determine the best plan to minimize variation.

Variation

- All work processes, from the most simple to the most elegantly automated, are subject to variation and reducing variation makes improvement.

Evolution of Health Care QI Programs

900 AD

Peer Review

- Medicare mandated, medical staff performance-oriented.

1979 **Quality Assurance (QA)**

- Reliance on inspection in the form of retrospective review without system-wide improvement techniques.

Quality Improvement (QI)

- Health care begins to recognize the advantage of systematic improvement with cooperation from different disciplines. (Interdisciplinary cooperation mandated in some areas by regulatory agencies).

Total Quality Management (TQM)

- The role of leadership is included in the regulatory QI standards. TQM was widely being used in other industries.

1986

Continuous Quality Improvement (CQI)

- QI models (Plan, Do, Check, Act cycle) were adopted to appease regulators that a systematic quality program is in place. Industry begins to look at "outcomes" measurement.

1993 **Performance Improvement (PI)**

- Accrediting bodies broaden the concepts of QI and require benchmarking to meet the standard.

Quality Improvement – Current State

QI has been used as both a management philosophy and a scientific methodology with systematic data collection and analysis at its core. Any model of QI must be believable, sustainable and replicable, as is the case in the traditional scientific method of observation, hypothesis, testing, and conclusion.

- ***Evidenced Based Practice (EBM)*** – Evidenced Based Medicine, is the latest model of clinical improvement to become popular in Healthcare delivery systems. The principle methodology of EBM works toward the same goals as quality improvement processes in terms of basing decisions on systematically collected and analyzed data. The EBM methodology considers not only the most effective clinical intervention, but also the most economical. This approach is closely related to the CQI process.

- ***Malcolm Baldrige Criteria for Performance Excellence in Healthcare*** – The Baldridge criteria for performance excellence has been in existence for over a decade. More recently criteria were developed for health care. If used, these criteria encourage overall organizational assessment, facilitate the use of best practices and work toward improved organizational performance through the use of QI principles. The criteria can be used as a systemwide model for performance improvement.

- ***Six Sigma*** – This method is based on a structured, disciplined approach using steps known as DMAIC. DMAIC is an acronym meaning Define, Measure, Analyze, Improve, and Control. The goal of using this methodology is to achieve “Six Sigma” or 3.4 defects per million opportunities. It is just beginning to be utilized in healthcare.

- ***PDCA*** – While a number of QI approaches exist, one of the most widely adopted is the PDCA method. The “Plan, Do, Check, Act” framework was developed by Walter Shewhart and can be known as the Shewhart model of improvement.

What is Lean?

- Lean is a systematic approach to **identify and eliminate waste** or non-value-added activities in a supply chain or process by **continuous improvement** through **participation of all employees**
- Lean strives for perfection by providing a defect-free product/service, one request at a time, when wanted and needed, safely and with no waste
- Provide the right **products or services, at the right time, at the highest possible quality, and at the lowest possible cost.**
- Doing what the customer needs, when it is needed, the right way, the first time

Value-Added and Waste

- "Value-Added" is from the customer's perspective.
  - Who is your customer?
  - What is your product?

- **Value** - Activities that contributes to what your customers want our of your product or service

- **Non-Value or Waste** - Work that adds no value in the eyes of your customers – think of "TRIMWOOD"
  - Waste of Transportation
  - Waste of Resources
  - Waste of Inventory
  - Waste of Motion
  - Waste of Waiting
  - Waste of Overproduction
  - Waste of Overprocessing
  - Waste of Defects (6 sigma)

- *Goal = Continuous flow of value-added steps*

Technology is Not the Solution

"Errors won't go away just because it seems logical that there should be fewer errors with more expensive equipment, more computerization, and more automation…

Orderly processes, when operated in an environment of disorder, will still be subject to errors. All errors are important and we must start by eliminating those most directly under our control."

James O. Westgard, PhD,
Professor of Pathology and Laboratory Medicine
University of Wisconsin Medical School, Madison
President QC Inc

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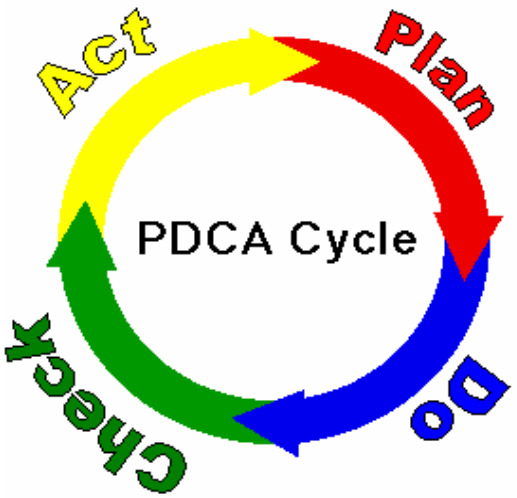
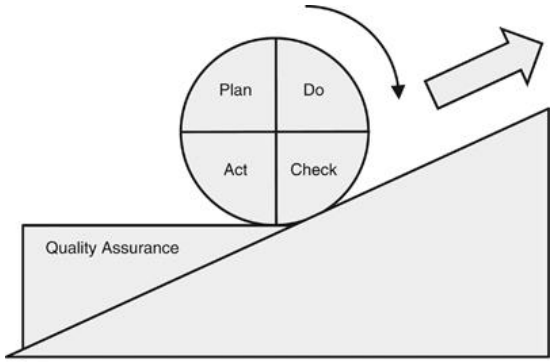
Deming Wheel or Shewhart Cycle

- **Step 1: Plan**
  - Problem Identification
  - Role Identification and Team Selection
  - Understand Current Process
  - Define Problems and Set Measurable Goals
- **Step 2: Do**
  - Establish Criteria for Solution
  - Develop and Analyze Potential Solutions
  - Select a Solution
  - Act on Solution





- **Step 3: Check**
  - Analyze Results
  - Monitor and Report Results
- **Step 4: Act**
  - Standardize the Solution
  - Adopt a System-wide Implementation
  - Plan for Ongoing Monitoring
  - Disseminate Information
  - Look for Other Opportunities

Walter Shewhart, the originator of the "Plan, Do, Study, and Act" process

Value Equation of Health Care

"Total quality activity can begin only if top management is conscious of the critical need for companywide commitment to quality and its own responsibility for introducing such activity" - Noriaki Kano

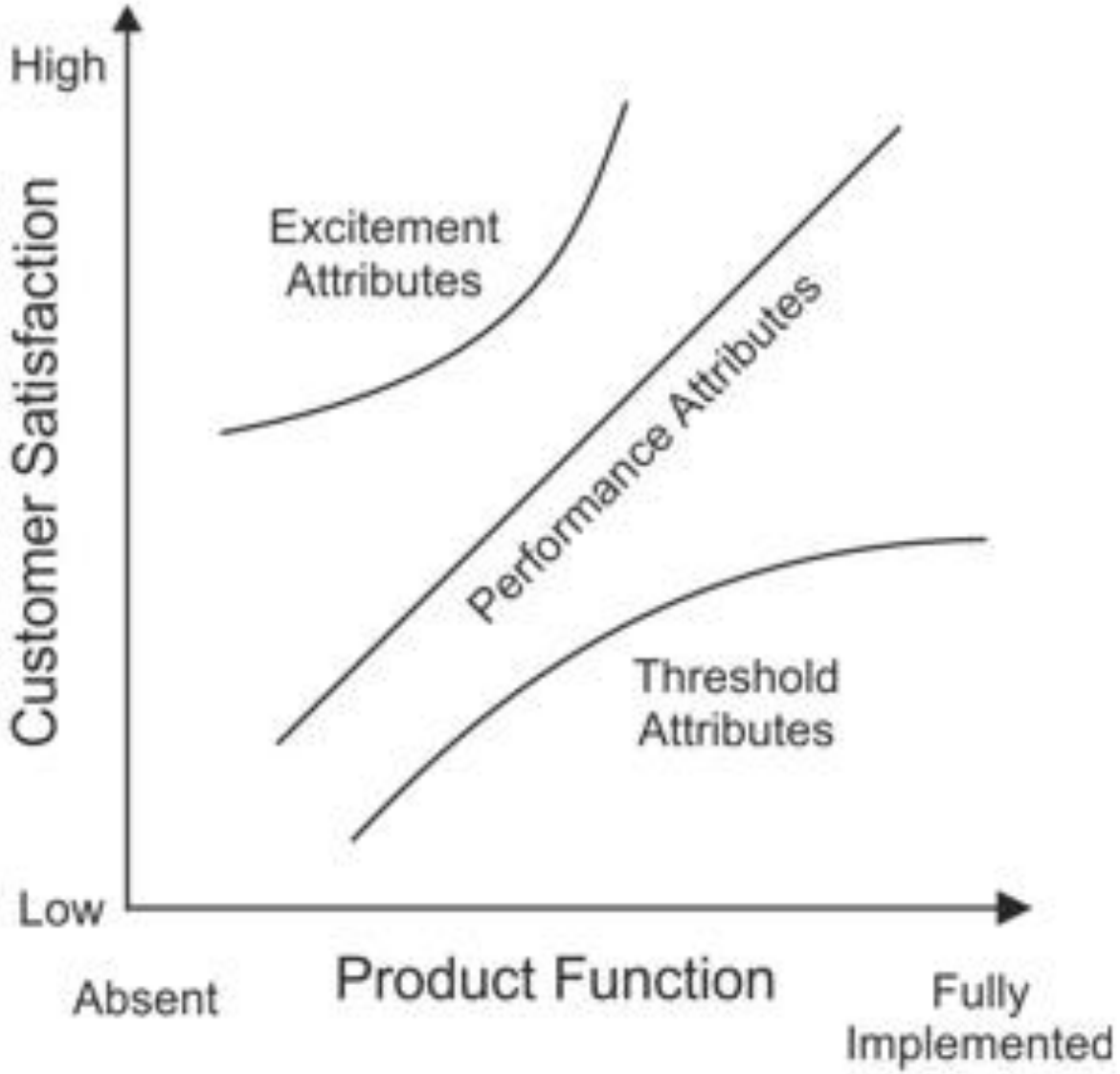
VALUE = QUALITY / COST

Although there are many strategies for reducing waste and enhancing value in health care, they tend to be isolated in focus and frequently do not address the system dynamics of health care.

Noriako Kano outlines three possible approaches to improving the quality of product or service – and thereby increasing value:

1. Eliminate the quality problems that arise because the customers expectations are not met
2. Reduce cost significantly while maintaining or improving quality
3. Expand customers' expectations by providing products and services perceived as unusually high in value.

Kano Model



www.mindtools.com

Process Improvement Toolkit

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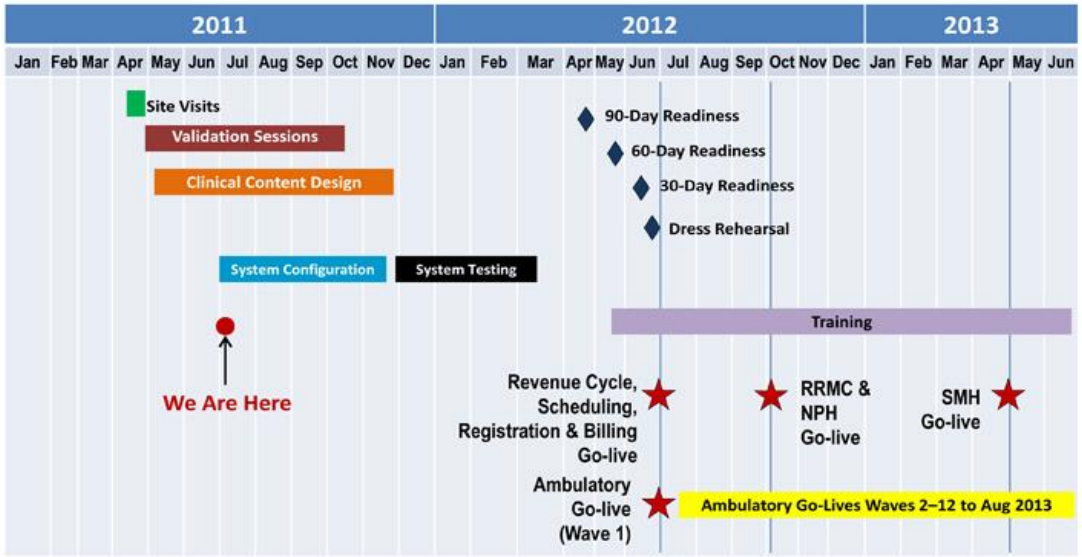
Process Improvement Toolkit:
Gantt Chart/ Project Plan

- Action Plan/Project Plan/Gantt Chart
  - An action plan is a list of activities needed to clearly indicate the who, what, where, when and how of the improvement process. This is needed to implement and monitor progress on the solution.
  - Gantt Chart is a visual tool that tracks progress against plan and display relationship against different tasks.



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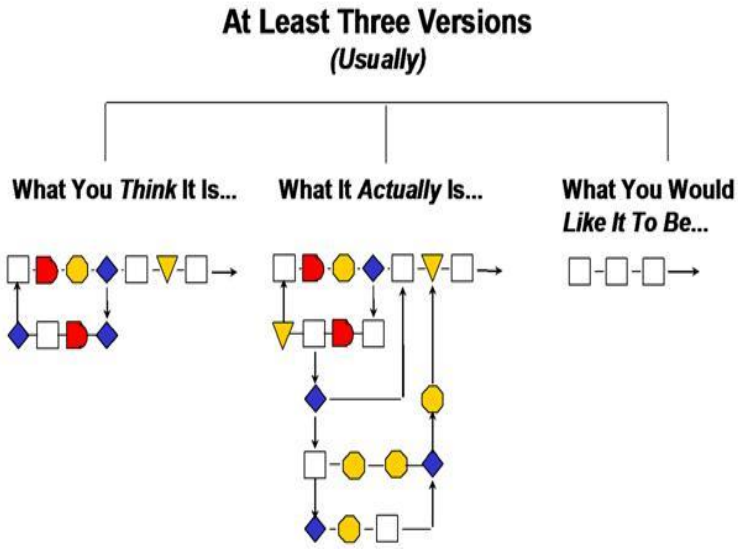
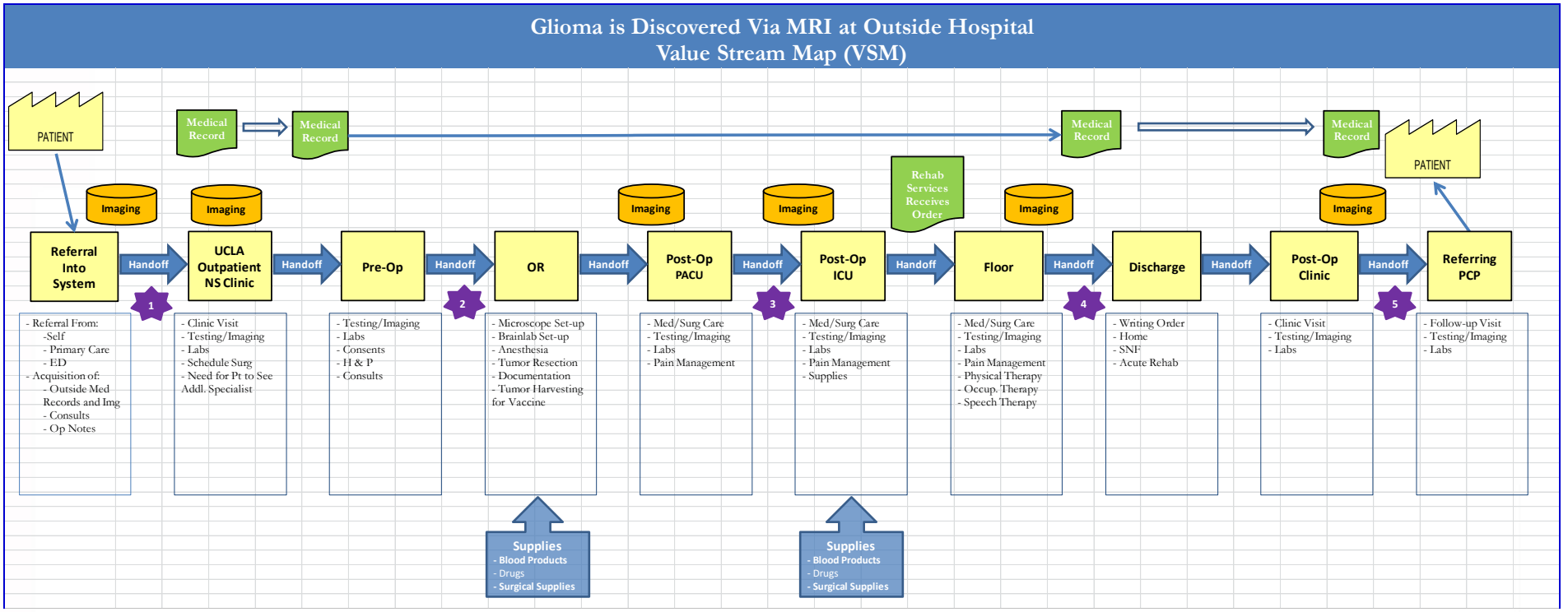
Process Improvement Toolkit:
Process Flow Chart & Value Stream Map

- A process flow diagram, often called a flow chart, is a graphic representation of the sequence of steps performed in producing some output.

- A value stream map accomplishes the following:
  - Enables an organization to understand its current process
  - Creates a common vision of what is achievable with quantifiable gains for everyone who is connected to the targeted value stream
  - Provides a plan with quantifiable gains to aim for in the short, medium, and long term
  - Provides visual roadmap for the team to allocate the appropriate resources



Value Stream Map Example



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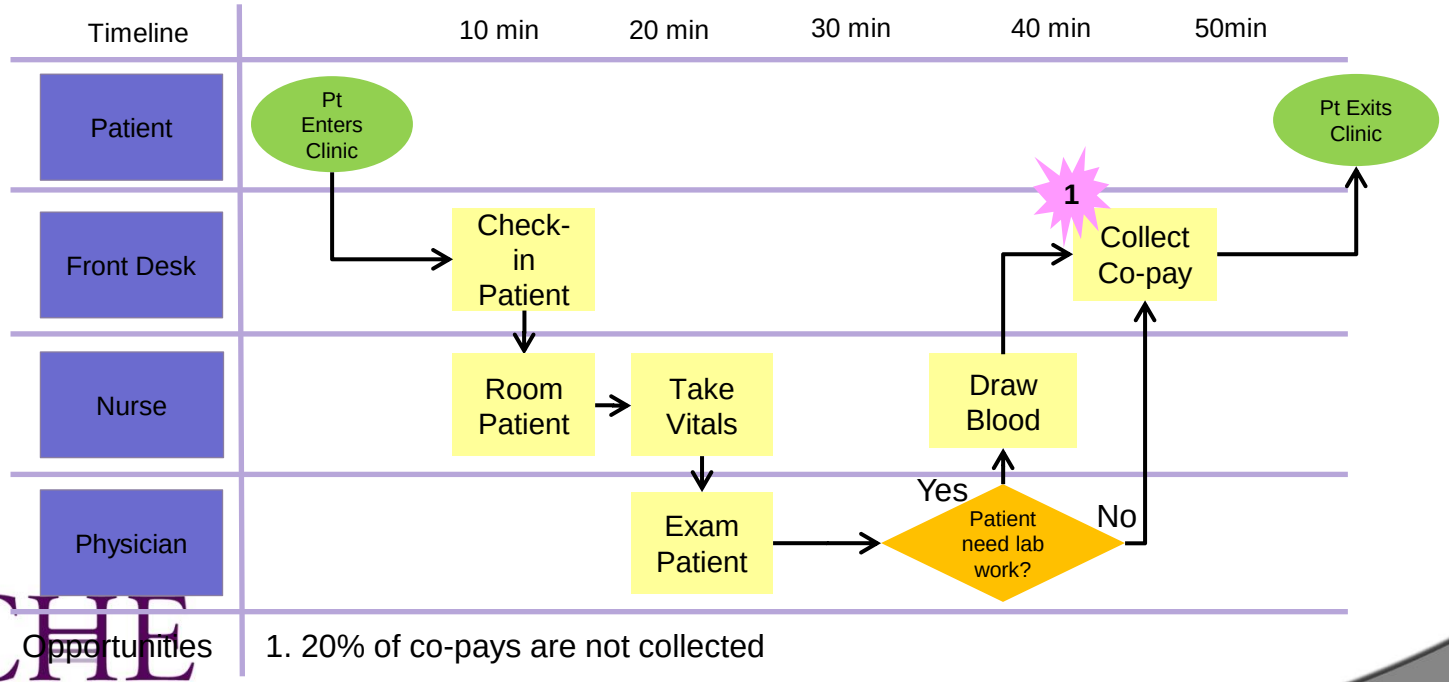
How to Draw a Process Map

1. **Define Boundaries**
   (Where the process starts and stops)
2. **Engage staff to List Functions**
3. **List Process Steps According to the Staff that Performs It**
4. **List Key Milestones or Running Time Across the Top**
5. **Identify Opportunities**



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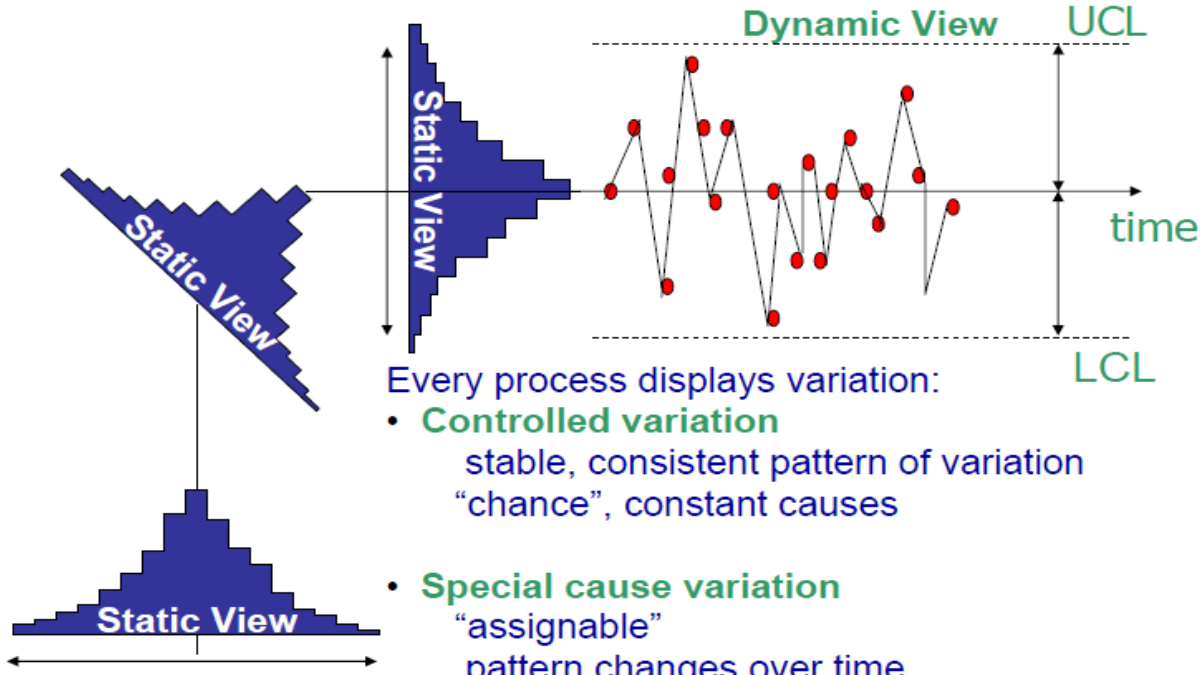
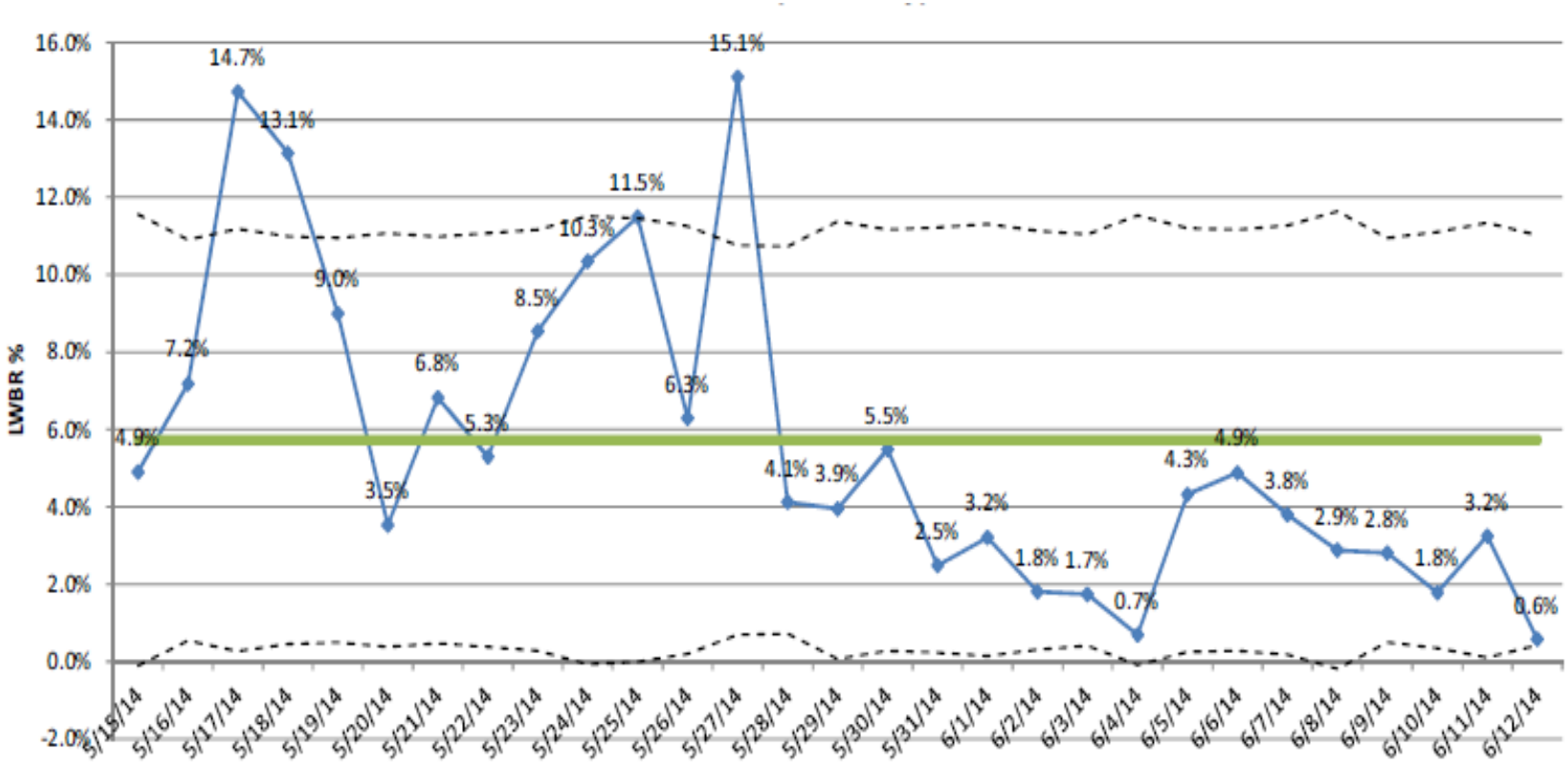
Process Improvement Toolkit:
Control Chart

- Control Chart
  - A control chart is a quantitative display tool to track performance over time by studying process variation and its source. It is a common language for discussing process performance. It measures the stability of the process and evaluates the progress after process change. It also distinguishes the special cause variation from the common cause variation. It is a visual way to identify acceptable and unacceptable trends.
  - Generally, control limits are established at three standard deviations from the mean--indication that 99.75 percent of the points will fall between the upper and lower control limits.



Control Chart Example:
Percent of Patients Who Left Without Being Registered (LWBR) in a Hospital ED



Did they improve?

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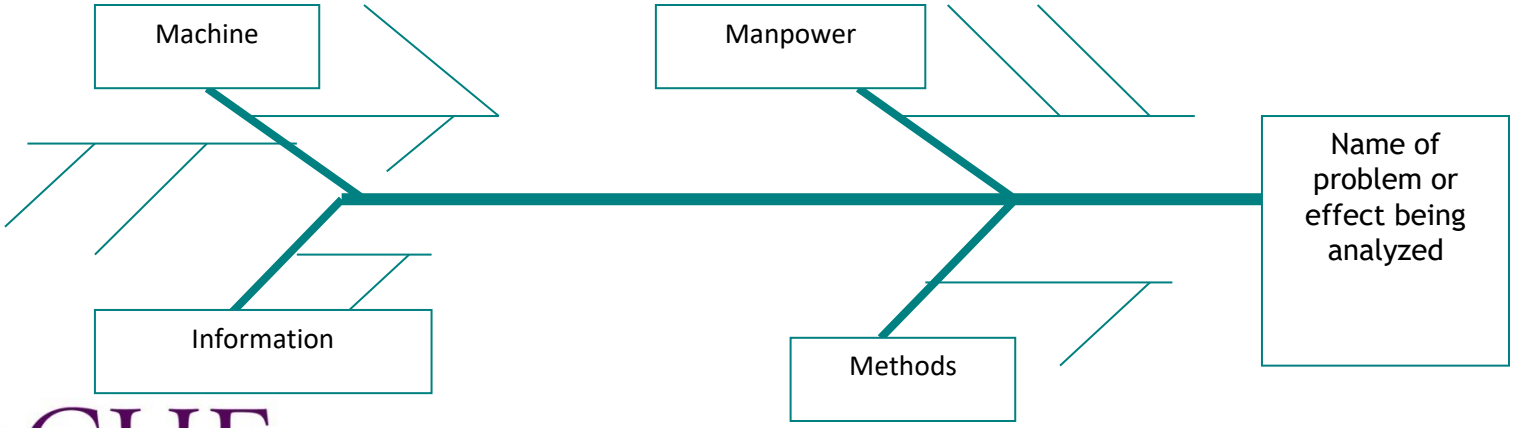
Process Improvement Toolkit:
Fishbone Diagram

- Fishbone diagram
  - The “fishbone” diagram is also called the cause and effect or Ishikawa diagram. The diagram helps to organize and display various ideas for the potential causes of a problem. Although it lists all the possible factors and the possible relationships between the cause, it does not show the magnitude of each possible cause. It creates a snapshot of the team’s collective knowledge by focusing on the causes not the symptoms. It also stimulates thinking during a brainstorming session when looking for potential causes. This also helps to discourage the jumping to an obvious solution.



Modeling

a. **PERT Charting** –

- **Program Evaluation and Review Technique** is a method to analyze the involved tasks in completing a given project, especially the time needed to complete each task, and to identify the minimum time needed to complete the total project.

b. **Stochastic Modeling** –

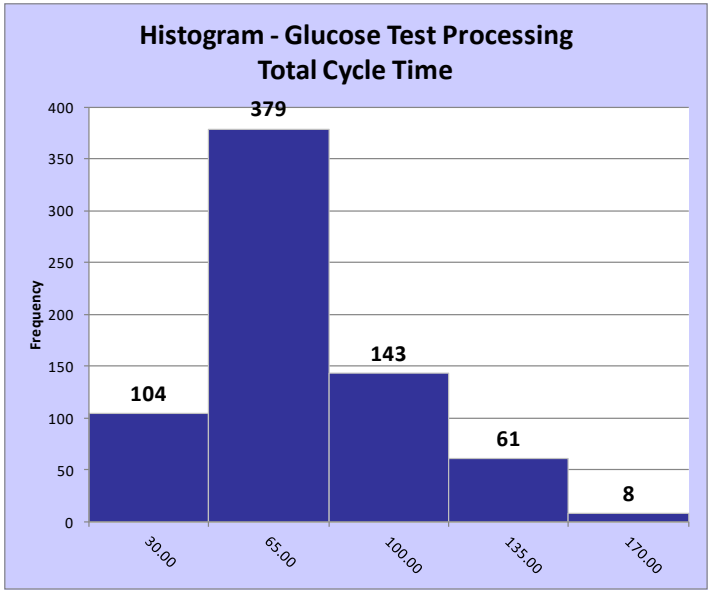
- Stochastic modeling is a technique of presenting data or predicting outcomes that takes into account a certain degree of randomness, or unpredictability.

c. **Monte Carlo Simulation** –

- A problem solving technique used to approximate the probability of certain outcomes by running multiple trial runs, called **simulations**, using random variables.

Process Improvement Toolkit:
Histogram

- A histogram is a quantitative data display tool that summarizes data from a process that has been collected over a period of time. It graphically presents and analyzes data as a frequency distribution and variance. Information is presented in bar graphs to make it easier to identify distribution patterns. It provides useful information for predicting future performance and helps to identify possible changes in the process. The tool may help to facilitate root cause analysis or to determine if the process is capable of meeting customer needs.



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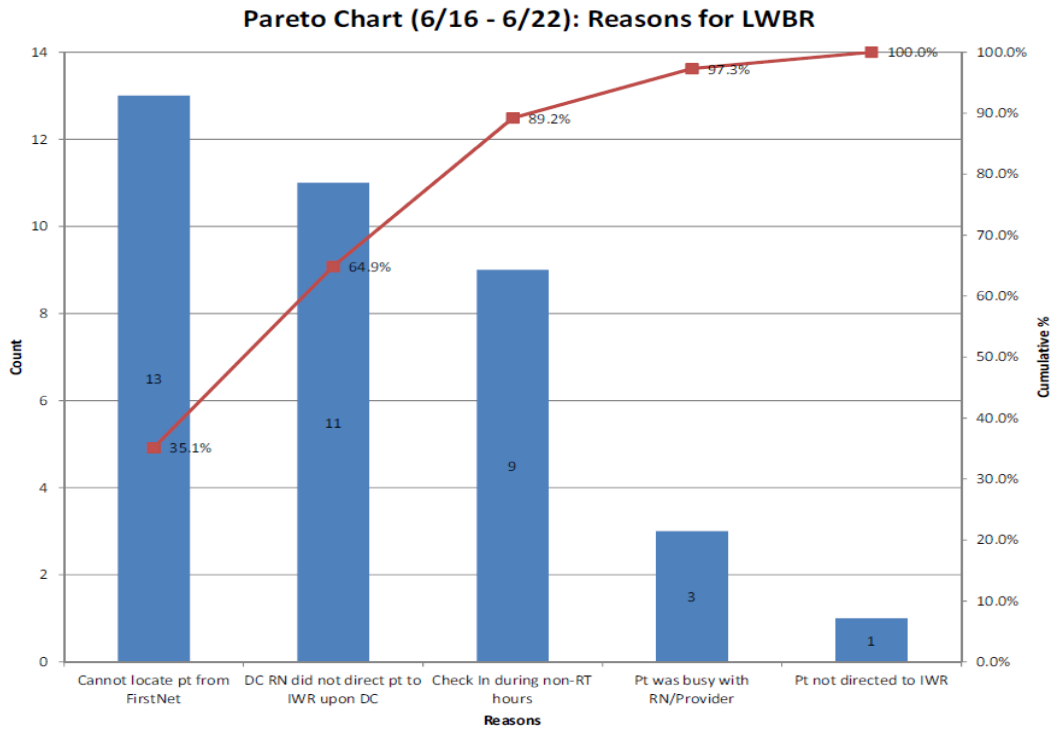
Quality Improvement Guidebook

Process Improvement Toolkit:
Pareto Analysis

- A Pareto Analysis is a quantitative data display tool that shows relative frequency or size in a bar graph allowing determination of the most important issues. It displays the pattern of occurrence for a problem by ranking the most-frequently to the least-frequently occurring issues. The tool helps to select and define the “vital few” improvements that will give the biggest yield. It can also help to build consensus in the group.



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Quality Improvement Guidebook

Process Improvement Toolkit:
Benchmarking (1 of 2)

- Benchmarking
  - Benchmarking is a tool used to measure your process against best practices. It specifies processes and results that represent best practices and excellent performance in similar activities, inside and outside of the organization. It adds objectivity to assumptions regarding the performance excellence since most people believe they are doing excellent work.
    - *Internal Benchmarking* – Compare within the organization for similar process, product or service.
    - *Competitive Benchmarking* – Compare your organization against your toughest and best competitor.
    - *Functional Benchmarking* – Compare your organization to a "world-class" organization in the same industry.
    - *Generic benchmarking* – Compare yourself to a "world-class" organization not in the same industry but using similar processes

Service Access Metrics	Goal	11-Mar	18-Mar	25-Mar	1-Apr	8-Apr	15-Apr	22-Apr	29-Apr	6-May	13-May	20-May	27-May	3-Jun
6ICU														
ED Green Light Placement Times	1:00	1:25	1:14	1:14	0:54	0:50	1:16	0:44	1:02	1:04	1:26	1:11	1:16	1:18
ED Request to Patient Ready	1:00	0:45	2:20	1:07	1:14	1:14	0:55	2:12	1:01	0:47	0:42	1:17	1:18	0:44
PACU Green Light Placement Times	1:00	0:50	1:31	0:50	0:51	1:29	0:41	0:40	0:56	0:59	0:51	1:51	1:06	0:44
PACU Request to Patient Ready	1:00	1:35	0:53	1:24	1:57	0:45	1:11	1:25	1:17	1:00	1:05	0:44	1:21	0:59
6N														
ED Green Light Placement Times	1:00	0:47	1:06	1:24	1:30	1:14	1:27	0:57	1:05	0:57	1:26	1:12	1:11	0:46
ED Request to Patient Ready	1:00	1:34	2:10	1:08	1:01	1:40	1:16	1:28	1:48	1:24	0:42	1:20	1:00	2:01
PACU Green Light Placement Times	1:00	1:21	1:02	1:08	0:52	1:09	0:59	0:48	0:47	1:11	1:03	0:50	1:11	0:43
PACU Request to Patient Ready	1:00	1:21	1:05	1:35	1:16	0:34	1:06	1:35	1:11	1:16	0:52	1:23	0:41	1:14

Infection Control	Target	Jan-Mar 2010	Apr-Jun 2010			Jul-Sep 2010			Oct-Dec 2010			Jan-Mar 2011		
6 ICU														
CA-BSI (rate per 1,000 pt days)	2.66	0.70	0.00			1.80			0.00			0.00		
C-Diff (rate per 1,000 pt days)	1.20	2.09	0.00			1.40			0.50			0.00		
MRSA (rate per 1,000 pt days)	0.00	0.00	0.50			0.00			0.00			0.00		
VAP (rate per 1,000 pt days)	1.94	1.00	0.00			1.40			0.80			0.00		
VRE (rate per 1,000 pt days)	0.85	0.00	0.00			0.50			0.50			1.00		
Handwashing MAPS Audits	100%	98%	96%	81%	83%	77%	94%	93%	98%	96%	96%	92%	95%	97%
6N														
MRSA (rate per 1,000 pt days)	0.41	0.49	0.00			0.00			0.00			1.40		
VRE (rate per 1,000 pt days)	0.20	0.00	0.50			0.50			0.00			0.50		
C-Diff (rate per 1,000 pt days)	0.51	0.00	0.00			0.90			1.40			0.47		
Handwashing MAPS Audits	100%	95%	86%	95%	86%	96%	86%	94%	89%	97%	NA	97%	97%	96%

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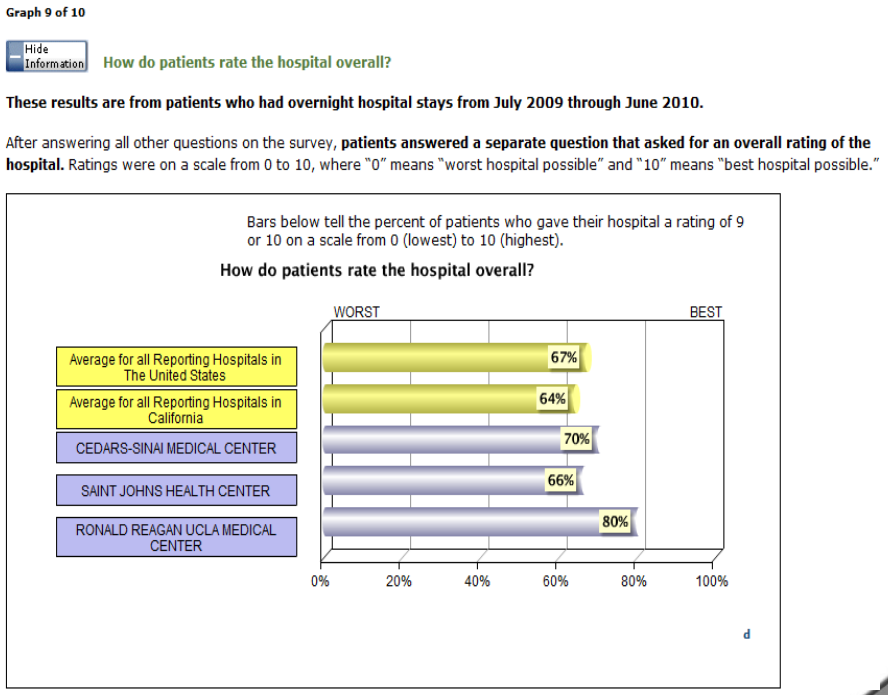
Process Improvement Toolkit: Benchmarking (2 of 2)

- HCAHPS - Hospital Consumer Assessment of Healthcare Providers & Systems
  - The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting
- Public Reporting
  - www.hospitalcompare.hhs.gov
- Press-Ganey & Gallup
  - Patient, Employee & Physician satisfaction
- Leapfrog Group
  - Consortium of businesses represents 40 million people
- Institute for Healthcare Improvement (IHI)
  - 5 million lives campaign
  - Providing leadership in evidence-based best practices



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Risk, Regulation & Reporting:
Quality Assurance & Clinical Review

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Quality Assurance

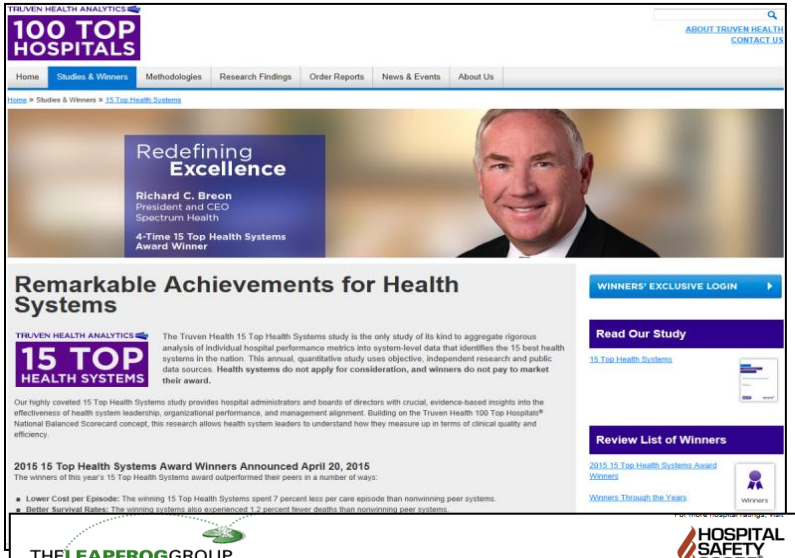
The **primary** purpose of the quality assurance/risk management program is to: **monitor, control and direct the institution's efforts toward achieving delivery of the optimal level of care.**

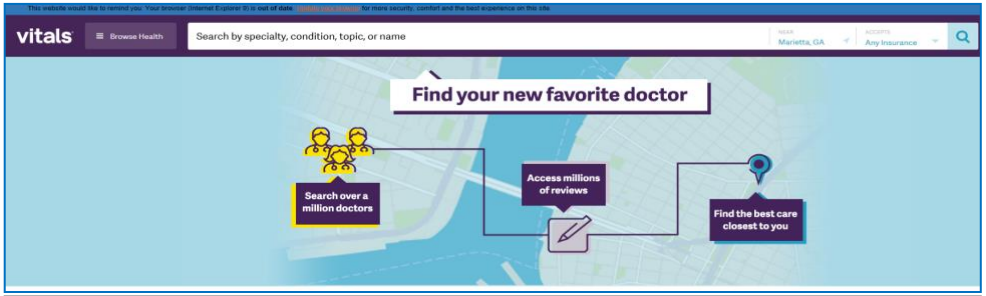
To increase the level of involvement among management personnel in quality assessment and assurance: **Develop an in-house program using trained key personnel for presenting and discussing quality assurance and its implications for the organization.**

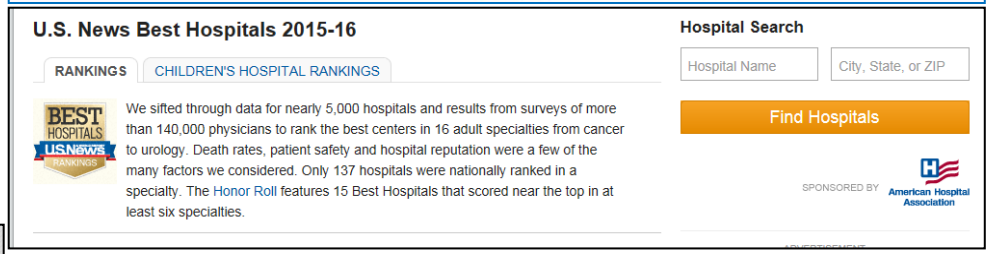
The governing body of a healthcare institution meets its responsibility for the quality of patient care by: **establishing, maintaining and supporting through the medical/professional staff and management staff an ongoing program of review and evaluation of patient/client care and action on findings.**

Continuous Quality Improvement (CQI): The reiterative process of improving stems from a philosophy that suggests quality is not something attained, but rather continually sought. The status quo is not sufficient.

Public Reporting and Ranking







Quality-Focused Organizations

National organizations that focus on improving healthcare quality (examples):

- Centers for Medicare & Medicaid Services (CMS)
- The Joint Commission
- The Institute for Healthcare Improvement (IHI)
- Leapfrog Group
- National Committee for Quality Assurance

The Joint Commission:
National Patient Safety Goals

- In 2002, The Joint Commission established its National Patient Safety Goals (NPSGs) program; the first set of NPSGs was effective January 1, 2003. The NPSGs were established to help accredited organizations address specific areas of concern in regards to patient safety.

- 2018 National Patient Safety Goal categories (16 goals in total):
  - Identifying patients correctly
  - Improving staff communication
  - Using medicines safely
  - Using alarms safely
  - Preventing infection
  - Identifying patient safety risks
  - Preventing mistakes in surgery

- A panel of widely recognized patient safety experts advise The Joint Commission on the development and updating of NPSGs.
  - This panel, called the Patient Safety Advisory Group, is composed of nurses, physicians, pharmacists, risk managers, clinical engineers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings.

https://www.jointcommission.org/facts_about_the_national_patient_safety_goals/

The Joint Commission:

Quality Improvement Core Outcomes

- In May 2001, the Joint Commission announced four initial core measurement areas for hospitals, which included acute myocardial infarction (AMI) and heart failure (HF).

- In November of 2003, CMS and The Joint Commission began to work to precisely and completely align these common measures so that they are identical between the two organizations. This resulted in the creation of one common set of measure specifications documentation known as the Specifications Manual for National Hospital Inpatient Quality Measures to be used by both organizations. Core Measure Sets Include:
  - Acute Myocardial Infarction (AMI)
  - Children's Asthma Care (CAC)
  - Heart Failure (HF)
  - Hospital Based Inpatient Psychiatric Services (HBIPS)
  - Hospital Outpatient Department Measures
  - Perinatal Care (PC)
  - Pneumonia (PN)
  - Stroke (STK)
  - Surgical Care Improvement Project (SCIP)
  - Venous Thromboembolism (VTE)

http://www.jointcommission.org/core_measure_set/

Center for Medicare & Medicaid Services: Conditions of Participation

CMS: Conditions of Participation

- Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare & Medicaid programs
- These minimum health and safety standards (24 conditions with 75 specific standards) are the foundation for improving quality and protecting the health and safety of beneficiaries
- CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called “deeming”) meet or exceed the Medicare standards set forth in the CoPs/CfCs.

Examples of Conditions of Participation:

- Compliance with Federal, State and local laws
- Governing body
- Physical environment
- Quality assurance
- Medical staff and nursing services

http://www.jointcommission.org/core_measure_set/

Center for Medicare & Medicaid Services: H-CAHPS

- Consumer Assessment of Healthcare Providers and Systems, Hospital Survey
- Collect and compare self-reported patient satisfaction
- Data available on CMS website (https://www.medicare.gov/hospitalcompare/search.html?)

Focus Areas of Survey:

- Nursing Care
- Physician Care
- Hospital Environment
- Hospital Experience
- Leaving the Hospital
- Overall Hospital Rating
- Understanding Your Care When You Left the Hospital

http://www.jointcommission.org/core_measure_set/

Medical Staff

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TJC Standards: Medical Staff

- The self-governing organized medical staff provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process
- The organized medical staff is also responsible for the
  - Ongoing professional practice evaluation (OPPE) of the competency of practitioners who are privileged
  - Delineating the scope of privileges that will be granted to practitioners
  - Providing leadership in performance improvement activities within the organization

TJC Standards: Medical Staff Bylaws

- The organized medical staff must create and maintain a set of bylaws that define its role within the context of a hospital setting and responsibilities in the oversight of care, treatment, and services

- The medical staff bylaws, rules, and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence

TJC Standards: Medical Staff Structure

- The organized medical staff must be structured using the following guiding principles:
  - Designated members of the organized medical staff who have independent privileges provide oversight of care, treatment, and services provided by practitioners with privileges
  - The organized medical staff is responsible for structuring itself to provide a uniform standard of quality patient care, treatment, and services
  - The organized medical staff is **accountable to the governing body**

TJC Standards: Medical Staff & Leadership (Governing Board)

- The hospital's governing body has the ***ultimate*** authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners (LIP), and other practitioners credentialed and privileged through the medical staff process or any equivalent process
- **Governing board is accountable for the quality of care**

TJC Standards: Ensuring Quality of the Medical Staff

- **Credentialing** – the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization
- **Privileging** – the process whereby a specific scope and content of patient care services (clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance
- **Peer recommendation** – information submitted by individuals in the same professional discipline as the applicant reflecting their perception of the practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of practitioner specific data collected from various sources for the purpose of evaluating current competence

Accountability for Hospital Quality

Hospital Board's delegation

- Hospital management
  - -System performance improvement
- Medical staff
  - -Individual & aggregate physician performance improvement

Peer Review

- **Morbidity & Mortality (M&M)** – The objectives of a well-run M&M conference are to learn from complications and errors, to modify behavior and judgment based on previous experiences, and to prevent repetition of errors leading to complications. Conferences are non-punitive and focus on the goal of improved patient care. The proceedings are generally kept confidential by law.

- **Peer review** is the process by which a committee of physicians examines the work of a peer and determines whether the physician under review has met accepted standards of care in rendering medical services.

- **Sentinel Event** is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
  - Such events are called "sentinel" because they signal the need for immediate investigation and response.
  - The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

- **Root Cause Analysis:**
  - What happened?
  - Why did it happen?
  - What are the steps in the process, as designed? (A flow diagram may be helpful here)
  - What were the most proximate factors?
  - What steps were involved in (contributed to) the event?
  - **What systems and processes underlie those proximate factors?**
  - Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred.

Quality & Reimbursement

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Quality & Reimbursement

- **Pay for Performance (P4P)** - P4P programs are designed to offer financial incentives to physicians and other health care providers to meet defined quality, efficiency, or other targets. Examples of recent P4P research and tools supported by the Agency for Healthcare Research and Quality (AHRQ) are briefly summarized here: http://www.ahrq.gov/qual/pay4per.htm

- **Transparency** – Transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services, so they can make informed choices among doctors and hospitals. In cooperation with America's largest employers and the medical profession, this initiative is laying the foundation for pooling and analyzing information about procedures, hospitals and physician services. When this data foundation is in place, regional health information alliances will turn the raw data into useful information for consumers.

Quality & Reimbursement

- **Physician Quality Reporting System (PQRS)** - was established by the 2006 Tax Relief and Health Care Act (TRHCA). Currently, PQRS is an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007.

- **Value-Based Purchasing** - The Centers for Medicare & Medicaid Services proposal, issued January 2012, incorporates 17 clinical process-of-care measures used in five health categories, acute myocardial infarction, heart failure, pneumonia, healthcare associated infections and surgical care improvement. It also will use eight measures from the **Hospital - Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** survey that reflects how patients view their care experiences.
  - These 25 measures will be used to generate FY 2013 DRG payments.
  - Hospitals have their funding reduced starting with 1% in fiscal year 2013, rising to 2% by FY 2017, but will have a chance to earn that money back, and perhaps more, under the incentives algorithm

Utilization Review

- Utilization review is a payor's opportunity to review a request for medical treatment. The purpose of the review is to confirm that the plan provides coverage for a plan member's medical services. It also helps the payor minimize costs and determine if the recommended treatment is appropriate. A utilization review also gives the patient the opportunity to confirm that their health plan provides adequate coverage for their particular condition. If the company denies coverage as a result of a utilization review, the patient can always appeal the decision.

- Most health plans have predetermined criteria or clinical guidelines of care for a given condition. Once a precertification request is submitted to an insurance company, a committee reviews these guidelines and determines if the patient has met the criteria for coverage. If necessary, the committee may contact your health care provider.

http://health.howstuffworks.com/medicine/healthcare/insurance/utilization-review.htm

Questions/ Discussion

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Appendix: References

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My BOG Test-Taking Strategies

- Participated in Spring 2013 BOG Study Series
- Spent two months after series ended preparing for exam
    - Exam date: August 17, 2013
- Did in-depth research in all areas of BOG study materials where I wasn't comfortable and/or got test prep questions wrong
    - Ended up with a list of 125 topics to review
    - Used mostly Google, Wikipedia, and HFMA
- Did not read "The Well Managed Health-Care Organization" at all (tried referencing a few topics but did not find answers in the book)
- Spent 1-7 hours studying every weekend
- Passed with highest scores being in Quality & PI (91%) & Finance (85%); lowest scores were in HR, Governance, & Laws & Regulations (scored in 60s for all three)

Practice Exam Questions

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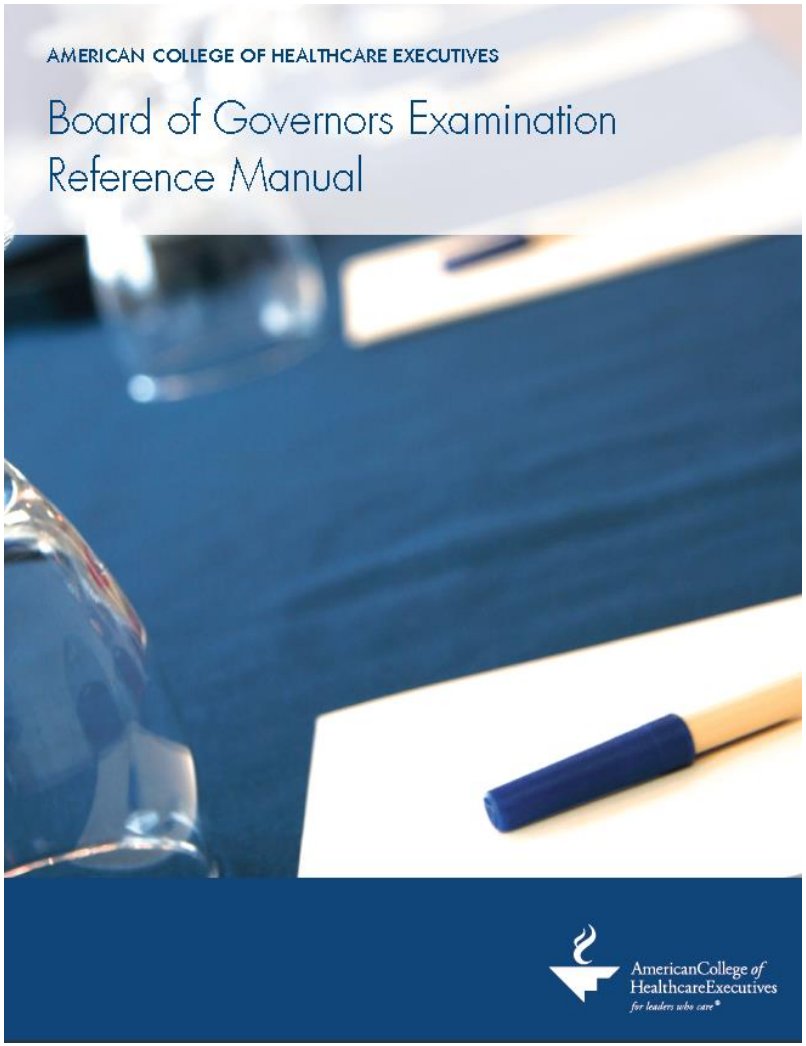
Preparing For The Exam

Refer to the Following Questions

- 2, 56, 75, 77, 109, 135, 162, 190, 191, 194



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Question #2

The principles of quality improvement require that healthcare executives change their philosophy from:

a. Finding fault with employees to finding problems in processes.

b. Finding fault with employees to involving them in the improvement of processes.

c. Focusing on enhanced inspection techniques to focusing on variance.

d. Focusing on employees' roles to focusing on process outcomes.

Question #56

Continuous quality improvement assumes that:

a. Achievement will be rewarded.

b. There is direction from top management.

c. There is no upper limit to excellence.

d. Interconnected work teams are in place.

Question #75

Performance improvement teams should consist of:

a. Experts in process management.

b. Members from the involved Microsystems.

c. Middle managers with experience.

d. Physicians and other users.

Question #77

A bar chart format, with the items rank ordered on a dependent variable, such as cost, profit, or satisfaction that Examines the components of a problem in terms of their contribution to it is known as:

a. A run chart.

b. A frequency table.

c. Pareto analysis.

d. Deming cycle.

Question #109

Which is the Shewhart process for performance improvement:

a. Plan, check, do, act.

b. Plan, do, check, act.

c. Analyze, formulate, implement, evaluate.

d. Analyze, implement, control, evaluate.

Question #135

Which of the following would be a discrete measure in continuous improvement:

a. Gender.

b. Weight.

c. Height.

d. Temperature.

Question #162

In a hospital setting, a critical pathway is best described as:

a. A document that focuses on efficiency and describes a standard set of activities to be performed for a defined category of patients.

b. A set of guidelines that focus on identifying those decision points which should lead to the consistent provision of appropriate clinical practice.

c. Any attempt to standardize clinical activities based upon diagnostic categories and projected outcomes.

d. Decision tree that focuses on physician decision making.

Question #190

The arrival of women for obstetrical deliveries or patient flow in an emergency department can best be analyzed through the use of which technique?

a. Pert Charting

b. Stochastic Modeling.

c. Gant Charting.

d. Monte Carlo Simulation.

Question #191

One approach for measuring technical quality of clinical support services is:

a. Patient satisfaction scores.

b. Degree of continuity of care.

c. Appropriateness testing.

d. Process review.

Question #194

The applicability of continuous improvement in healthcare organizations assumes:

a. An upper limit of improvement.

b. The physician's perspective is dominant.

c. An organizational commitment.

d. The elimination of outliers.

Questions/ Contact Information

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