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**Our Hospital’s Value-Based Purchasing Journey, Maple Grove Hospital**

Presented by Linnea Huinker and Katie Potts (51-minute Webinar) [January 31, 2013]

**Linnea Huinker:** I’ll be speaking today along with Katie Potts. We both work at Maple Grove Hospital. We are in clinical effectiveness and we’re both clinical effectiveness specialists and what we’re going to talk about today is our hospital’s value-based purchasing journey. I know we’ll talk about readmissions and I’ll talk briefly a little about what we’ve done with readmissions at the end.

We’ll talk a little about our hospital since we’re only three years old and many of you may not know about it. We’ll talk about our value-based purchasing journey as well as our general process and improvements and then we’ll talk about the next step. We’ll leave time for questions at the end.

So about Maple Grove Hospital, we are a joint partnership with North Memorial and Fairview so we’re actually 75% North Memorial and 25% Fairview and we are an independent entity. We opened just three years ago, December 30, 2009 so we are a baby organization. We are about 25 miles northwest of downtown off 94 heading on your way to St. Cloud.

We have a lot of orthopedic and total spine population. We have spine surgery, general surgery and medical patients. We have a lot of GYN population. We have a large family birth center. We have a level II B special care nursery and we have a very busy emergency care center. Some of our hospital focuses are around how we deliver exceptional care, focus on technology and the patient experience as well as the employee experience.

Our vision is of the hospitals together delivering health care as it ought to be. We have a very unique culture where everybody in the hospital really does strive to deliver health care as it ought to be.

Some of our statistics here are: in 2012 we had about 32,600 ER visits. We had 3,662 babies delivered, so a very busy family birth center.

**Katie Potts:** We have 8 labor rooms. When we opened we opened as a 90 bed community hospital and we just opened a fourth floor so now we’re at 240 beds. We are the second busiest labor hospital in the state. Last year we were third, so now it’s Abbott, Maple Grove, and United. So think about that in comparison to Abbott and United which are both connected to a children’s hospital.

**Linnea Huinker:** And we don’t have a NICU.

**Katie Potts:** We have a lot of community deliveries at our hospital.

**Linnea Huinker:** We had 3,352 in-patient admissions and our average is 2.5, so it’s short. We are busy and have a lot of patients going in and out. On one day we have 48 in-patient beds and we could have 30 discharges in a day sometimes.
We have a very high turnover rate, so our employees are running in and out and when 
you talk about all the improvement efforts we have going on you’ll see that it needs to 
be embedded in how they do their jobs, because we are a busy facility.

Then we had about 3,258 surgeries, in-patient and outpatient.

That’s a picture of what our hospital looks like. What about the Clinical Effectiveness 
Department? Does anyone else out there have a department called Clinical 
Effectiveness? No, most of you work in what’s known as the Quality Department or 
Quality Assurance Department, but we aren’t a typical quality department. When we 
first opened it was my manager and myself. Neither of us are nurses and he says you 
don’t need nurses in the Clinical Effectiveness Department. There are nurses all 
around us. If we have questions about nursing, we’ll go ask them.

We all have backgrounds in process improvement. Our Manager Mike is a Master 
black belt with an MBA and then Katie and I both have MHAs so we come from 
process improvement and project management backgrounds. The director who we 
report to is Director of Acute Care Services. She is an advocate for us as a 
department. We meet with her weekly about strategies and what we’re going to focus 
or time and efforts on and she is our link to the senior leadership team to make sure 
what we’re working on, that they know is important to the rest of the leadership team.

So that’s public relations and communication, the finance department, that’s materials 
management, everybody knows the initiatives of us in the Clinical Effectiveness 
Department.

**Katie Potts:**

Again, unique to our hospital we don’t have a traditional chief nursing officer role. We 
have two directors of nursing. We have a family care service director who oversees 
surgeries in our family care center and special care nursery and then who we report 
to, she’ll receive the med surge unit, ICU, pharmacy, the lab, ECC (emergency care 
center). So it’s more of a dyad model with those two.

**Linnea Huinker:**

And OCO is very engaged as well, he pops into our office often to talk to us about 
projects. He knows about core measures and patient satisfaction. He’s very engaged 
in all the things that we’re talking about. Oftentimes, we prepare all the information for 
his presentations that he gives, but we give him little notes to make sure he knows the 
details of what he is presenting and talking about.

Our department is small but we do a lot. We have one manager. There are the two of 
us that are the Clinical Effectiveness specialists and about a year ago we added a 
data management specialist who helps us with a lot of the general data and other 
projects as well.

What we oversee in our department is all our clinical outcomes of core measures. We 
have patient satisfaction and surveys. We do all the safety initiatives for all the 
roadmaps that NHA puts out and everything like that’s—safety and incident reporting, 
all our adverse health events. Another report came out this morning, all of our stop the 
line, so we do a stop the line events to make sure that if we have a safety incident in 
the hospital that we have quick rapid action coming out of all the safety concerns.

**7:00** services, indirectly our manager does have a say in over case management and 
social services, so Katie and I don’t do as much with that. We look at hospital flow and 
through-put, care coordination which has to do with readmissions and discharge 
information and that whole concept of working with the nursing department on 
coordinating care. Regulatory and accreditation, we’re getting ready for a survey 
coming up at the beginning of March.

Risk management and just general process improvement and support for basically the 
entire hospital and usually there’s somebody from the Clinical Effectiveness 
Department on every committee.
We help and support with data, look at process improvements in general and make sure we are having improvements coming from every group and committee that’s meeting.

To focus on value-based purchasing and what our journey was like, we started focus on this pretty early, May/June of 2011. I know many people here might not have gotten focus until the end of 2011 beginning 2012, but the first time I heard of value-based purchasing it was from our patient satisfaction survey vendor. We use NRC Picker for our patient satisfaction surveys and they’re the ones who I first started hearing about this from. We then started thinking this is the performance paper that’s coming that I heard about when I was in the NSA program in school. Here it is so we have to get on the bandwagon early.

We did and we started hearing information from our core measures vendors and we used formerly the QI project now called Press Ganey Quality Performers, so that’s what we use for our core measure vendor and we’ve participated in many of their external webinars that they housed. Often times, it’s very one-sided. If it was a vendor from NRC Picker they’d only be talking about the patient side of value-based purchasing. If it was a presentation from our core measure vendor it was very one-sided on that aspect.

So it wasn’t really until we needed to sit down and study the final rule to really get the big picture about how this was all coming together. So that’s what we did. Katie and I have the final rule in our small office and we’re sifting through it reading, writing down the numbers and we started creating our own tools. Internally, we set our dated resources to monitoring and looking at value-based purchasing.

As the person who has been looking at core measures from the beginning since we opened, it made perfect sense that I be the person looking at the core measures portion of value-based purchasing and even though everyone in the whole hospital is involved with patient satisfaction, Katie has taken the lead on looking at the aspects of the data for the patient satisfaction portion of value-based purchasing.

So, we as a team went through the entire hospital to make sure that it wasn’t just the Clinical Effectiveness Department that understood what was going on with value-based purchasing (VBP). We need to make sure that all our leaders understood what VBP is. Most of you all know what it is, but does everyone else understand the acronym and what it means? We brought this information to leadership, all the process improvements we have around HCAHPS and each of the core measures, our medical executive committee, medical staff meetings, and front line staff.

So our managers who are at the leadership team meetings, they need to bring that information to the front line staff. They may not need to know the nitty-gritty of the 1% and how those graphs are broken out, making money and losing money but they need to understand the basics.

Basically, we made sure that CMS is withholding 1 percent. They’re redistributing it based on your performance. High performing hospitals are going to make money, a lot of people will break even and then some low performing will lose money. So we needed to make the message simple to those who need to understand it. We needed to know the details in our department but then different people and then whoever your audience is we needed to change that message to how it’s going to affect them and to their jobs.

Katie Potts: Once we knew the final rule and had to make it real for our leadership team, Linnea and I were tasked with how do we bring all these tools to the front line staff and we looked at several tools already out there and as Linnea mentioned our HCAHPS vendor is NRC Picker and they offered a dashboard. Again, it only showed a small snapshot of one piece of the pie.
Then we had our Press Ganey, which had a calculator for the HCAHPS measures, but again they weren’t talking to one another and until the Stratis Health dashboards came out and you can only see one strong snapshot. Again as Linnea mentioned we opened in 2009 so we didn’t have any baseline data that we would have opportunity to gain improvement points, so we were tasked again with being creative and building our own calculators.

So again we sifted through and understood all of the equations and we built a calculator which we want to quickly show you and we used that to portray to our leadership team what’s going on with VBP. What you have in your packet is a calculator we built for our core measures and this shows the breakdown and we grade out our points, which isn’t important, but what we wanted to show you is we then have an opportunity for improvement points.

We were able to look at what were the benchmarks, what are the achievement thresholds and how many points we needed to get. At the bottom of the screen you can see our total performance points and then how we rated it. Some of the measures didn’t apply to our patient population, for example, the AMIs we didn’t have a large enough sample so we didn’t report on those measures.

One thing I’m thinking that you are all familiar with is when you have small patient populations missing one measure dramatically impacts your performance. So as a community hospital that’s one of the things we really struggle with is how you have a top performing hospital and really help front line staff understand the importance of meeting all these measures and most importantly we found the engagement of the physician.

So having a medical director or section lead that can be a champion for you was influential in helping us maintain our high performance.

Then MGH achievements score column, you can see our total points that we’ve achieved and estimated what we would have achieved based upon the achievement threshold and benchmark and then the rated score is there. Similarly with our HCAHPS scores we looked up the 8 different domains and compared our score during a performance period to the four minimum achieving threshold on the benchmark.

Again, our hospital had to strive to meet the achievement threshold because we weren’t awarded any improvement points as we had no baseline data, so really our goal is to continuously be above the achievement threshold and based on the equations from the final rule we were able to estimate our total achievement points. So for last year we would have achieved around 25 points and then we also use the consistency score measure there and so our consistency score measure was based off our communication with the doctors’ score, and we were awarded 18 points there. We estimated it to be around 43 points.

We took the weighted averages of these two and to get what we thought would be a total performance of around 75 points, and we were really striving to be at 50 and thought that would be the breakeven point, so we felt comfortable with that and when the final rule came out we saw 75 points put us above the 1%. That’s how we broke down our first round of the fiscal year 2013 VBP, even our own internal resources.

Then, in October, after we presented all this information we did receive our final rule from CMS for fiscal year 2013 and Linnea worked closely with our finance manager to understand the impact of our performance on reimbursement moving forward, so all the payment October 2012 through December 2013 is how you would be reimbursed. Calculated risk dollars for last year were the 1% and now you know they’re increasing to 1.25% and 1.5% so it’s getting to be more and more. For last year it was 1% so we used our VBP multiplier which comes from CMS and we calculated our dollars earned.
So we took our September 2012 year to date in patient DRG charges and with our finance manager we annualized that. We calculated that for how many millions of dollars we were charging for our CMS patients. We still have some things in there from expansion and volume growth and then we use our calculated rate which at Maple Grove is about 32%, which may differ depending on your demographics and patient population.

From there we were able to calculate that revenue estimate, so it’s still an estimate about what your percentage at risk dollars would be and what you could hope to earn back and then you use your 1% at risk and the multiplier from your VBP to calculate your total years and what you could hope to earn back.

When you say this to someone who doesn’t understand VBP or isn’t close to the work they get a little lost, so what we’ve come up with is a really great scenario. You look at your hospital collection rate for your CMS, let’s just say your hospital is at 32% and you have a patient that comes in and out, maybe their charges for CMS are about $10k. At the end of the day what do you hope to expect? Let’s say you hope to expect about $3,200 payment back.

So if CMS is withholding that 1% back that’s $32 and then they say based upon your performance over the past year you earned X amount of dollars back based on the multiplier, so we hoped to earn back $44.16. So, on a $10k charge, at the end of the day what does that mean? For a high performing hospital you may get $12.16 back. But, over time and with a lot of different patients that can add up so to put it into perspective about cost of health care and making it real for front line staff. It will definitely be increasing by 2017 with over 2%

**Linnea Huinker:** I think one other important thing is that making sure when you’re going to committees is that you have that elevator speech ready. We present patient satisfaction and core measure data to almost every medical staff meeting every other month and we have the spiel ready about VBP even if say for every other month there may be new physicians present at the meeting. We give the same spiel over and over and it might sound like a broken record but people need to know what this is because it’s not going away.

The challenging thing is that you have messages to come back with for difficult physicians who say, “Well, if we only made this much money why can’t we just hire an extra person to make sure we are 100% for everything”? However, we all know that’s not the culture of improvement, the culture of improvement needs to come from everybody. It’s not just one person.

**Katie Potts:** Now with the 24 team we are able to use the Stratis Health snapshot tool. The whole point of using this is it’s made our jobs much easier and it’s also to spin some more concrete numbers for us to react to. The top is your core measure performance and then your HCAHPS and then at the bottom are the outcome measures.

With this new reporting that just ended at the end of December, we had to relook at the pie and we see there’s different distribution. We saw the added outcome measures of 25%, the reduction rating of our clinical process measures, but really that the 30% patient experience domain stayed the same. So as we begin to look at the pie, we’re emphasizing that these things can’t be working in silos anymore. So at Maple Grove Hospital we are trying to bring different departments together.

Especially now, with the 25 team coming out, your finance can’t be working in one direction, your front line staff and core measures working in one direction, and patient satisfaction going the other direction. So it’s important to bring everything together.
As Linnea mentioned we do present these dashboards to a director team which meets weekly and includes all our senior leadership and board of directors from Fairview and North Memorial, so they have an understanding of how we’re doing. It’s fast acting in real time.

**Linnea Huinker:** I’m going to talk a little bit about our general process implement model at our hospital and then how we communicate performance as well.

Like any hospital, we have improvement teams for pretty much anything and everything. Some of it is patient safety, some is core measures and some is just internal hospital focus improvements that we need to do because of internal issues. One thing we’ve noticed about VBP is that we’ve kind of made a focus on everything.

So we need to at least focus and monitor everything, but we can’t have focused improvement projects on everything because you’ll tire your staff out. We learned that we need to monitor every aspect of VBP, but we need to pick little things here and there for what we’re going to focus some of our actual improvement methods on. In the last year we did picks in certain areas and I’ll talk about what we did with our core measures and Katie will talk about our improvement efforts around HCAHPS.

With HCAHPS we wanted to focus on what our lowest performing area was that will drive our consistency point. That was our communication with physicians and our pain management scores. Then with core measures, we all know of the 12, several of them are skipped and so we needed to focus on our skipped measures as well.

With all these improvement efforts we’re very transparent with our data. We did not have VBP on our hospital quality scorecard. We had it on for a while and just thought it was too confusing, but we do have all the different components of VBP represented. We have all our core measures represented on our quality scorecard, as well as our outcome data and our patient satisfaction data.

So we might not have a VBP score, because it’s too confusing for everyone but we have the different components so we know we’re monitoring and know how we’re performing at that standpoint. We do have monthly VBP dashboards pushed to our leadership team from our vendor, so obviously everyone on our hospital leadership team can go in and look at the data and some managers will get that daily. We want to make sure we’re pushing the data to them monthly just in case they aren’t going in and looking at it, so we can see how their performance is going with their patient satisfaction.

Then, we’re always working closely with the directors team, leadership team, finance team and our board and giving quality updates, not for VBP but for core measures, section data and leaving general quality updates for all those communities.

As far as core measures, since many of you here are basically the people who do the core measures at your hospital, we have process improvement committees for each of the core measures, so since we are a small hospital we started with heart failure, pneumonia and SCIP. Then last year we added our EF core measures committee. Now we’re adding a stroke core measure committee and more, so we’re adding on these little committees to gather together the people who need to be a part of it.

We have an administrative champion who’s usually our director, but sometimes for surgery it’s the other nursing director who is our administrative champion. We always have a physician champion. Usually for our heart failure and pneumonia we have a hospitalist and then for the pneumonia ones we have an ER physician who is the champion on our team. We always have pharmacy on the team and front line nurses.

Clinical Effectiveness, we’re always obviously supporting the team and our SCIP work. We communicate closely with our surgery team, medical staff, anesthesia, who are all tied into SCIP. We review all the core measures and look at general process
improvement at those committees and we review every missed measure. Robin was just presenting on basically one of the sheets and doing an RCA on every missed measure.

So we’ve been doing that since we opened so if we opened three years ago then we’ve been looking at every missed measure since we opened and I don’t know if everyone was doing that three years ago. I don’t know if hospitals were looking at every missed measure until VBP hit them. Because we have been looking at it since we opened, that’s why we have such high performance with some of our core measures. We knew the changes we needed in Epic to be better at foley catheter and things like that.

We had innovation going on to see how we could do things differently within our charts or nursing staff, but we’re monitoring our performance weekly and/or monthly with our core measures and looking at our performance to help prevent recurring missed measures. We try to do it as real time as we can. Obviously our attraction was retro, but what we did was to create core measure checklists probably within the first year that we opened.

I think we had all checklists for core measures by that summer time, when we weren’t actually required to report yet, because as a new hospital we’ve had a built up timeframe for when we were required to report our core measures. So we had a practice period, which was nice, where we could have a checklists on the floors, have the nursing staff use the checklists but we didn’t actually have to report data.

Our checklists are used by our patient care facilitators. Our patient care facilitators at our hospital are a glorified charge nurse. They don’t usually have patient assignments but they are looking at the big picture of quality on their unit. They’re looking at satisfaction with their patients. They do rounding and monitor core measures as well. We have daily interdisciplinary morning rounds with the doctors, the pharmacists are there, the social workers, home care and the charge nurses and they’re identifying patients who will be core measure patients. Then they’ll initiate the checklist and they’ll get going on the requirements right away.

They are tweaking those checklists all the time. We’re making things clearer as issues come up if they don’t understand something we are doing rapid cycle improvements with making sure the front line staff understand the core measures. That checklist allows for the real time monitoring of core measures and if they don’t understand the information at the bedside then we aren’t going to meet our core measures and we’re then doing retro chart abstraction.

Sometimes I’ll be in a meeting and get information where they say well, we need you to come look at this chart because this doctor doesn’t want to give this prophylaxis so are we going to be okay? They know that the measure is based on the checklist. They have all those idiosyncrasies and they may not be the experts but at least they know where their resources are. So they can have the tool from the checklist but then they know who to go to for complex patients and that’s where we are always accessible to people when they have questions.

But like Katie said earlier, when we looked at our actual scores, since our numbers are low, our denominators when we first opened were probably sometimes 10 heart failure patients, maybe four in a month but now we’re probably more at like 15-20 a month. We know if you miss one, then you’re lost. When you’ve been at 100% for heart failure for the past few years, our staff needs to know the significance of 100%, 99% isn’t good enough.

We know that for VBP, 99% isn’t good enough. You have to be at 100% for a lot of those measures and staff need to know that it only takes one and sometimes that’s scary for the staff, but they need to know how important these core measures are and that’s really what we try to convey to them at their staff meetings, making sure they
have the scorecards available and making sure the physicians know their aspect of it as well.

We do our abstraction a little bit differently here at our hospital. Like I said we opened three years ago and neither I nor the manager had a nursing background, we had never worked with core measures before, so we were curious as to what we were going to do. We didn’t have a nurse in the department so we decided to tackle core measures in a different way for abstraction.

So we decided we have all the nurses around us so let’s pair up and figure this out together. So, from the very beginning we did our abstractions hand-in-hand together and I became the expert on the specifications manual and then the nurse who I do the abstractions with became the expert on their charts, their documentation, workflow, how they’re charting and all of that. So we work together to do the abstractions until now that they really are on their own.

I have oversight over all of the core measures and abstractions but the benefits of having one of our PCFs do the abstraction for each different area, they’re kind of focused so we have surgical services in their SCIP abstraction. We have a different med surge nurse doing the abstractions for heart failure and pneumonia but they have the ability to understand and affect their documentation and their peers. If we have a missed measure and it’s usually because of documentation, how do we affect change and get that message and understand why it was charted that way?

They also have the ability to become the unit expert on their core measures and that’s the model we’ve done on our core measures from the beginning. I think part of that is how we’ve become so successful is because we have unit champions for core measures but they know about it. I can’t tell you when we opened three years ago how many nurses had never heard of SCIP, including surgical nurses so they’re the ones at the bedside giving the beta blockers. They’re the ones at the bedside making sure they have the right antibiotic orders.

Now I think every nurse knows about SCIP. They know about the heart failure core measures and the immunizations, so we’re getting there but it takes little steps.

Our abstractors are not in our Clinical Effectiveness Department. They are staff nurses. They work with the manager to have office days and then I give them the patient list and sometimes we do it together. Sometimes they do it on their own. Now as we’re growing, we don’t know if that’s going to sustain us in the future, but it worked for us when we were small and it got us on our feet about getting staff involvement. We just don’t know where it’s going to lead us in the future. It’s worked well for us in the past.

Katie Potts:

So, with our performance improvement initiative around patient satisfaction, unlike the core measures we didn’t have dedicated teams focused on each of the domains. We incorporated the HCAHPS focus into existing teams. For example, one of the things we had is a medication improvement team and they focused on the medication information questions within their team, so process improvement work they do may be around a formulary or side effects and modifications.

They always keep in the back of their minds, “How are the patients answering the questions around medication improvement?” Another example would be around our discharge information and communication with physicians. We incorporated this process improvement work into some of our care coordination teams. One initiative that we focused on was real communication at the bedside.

So for our MD communication scores and our discharge scores we focused on communication through the white board. We had a front line staff team of nursing assistants, RNs, and some physicians involved as lead roles recreate and redesign a white board within the family birth center. So they were focusing on what they needed
to know as the provider, what they needed to know as a nurse and what does the patient and family need to know.

Through that we saw increases in both our communication with physician scores as well as discharge scores. So particularly in the special care nursing we've adopted a model to have communication and conversation with the family around the day, the stay and the way home. That's been our mantra as you look at that care coordination.

Additionally, we have partnered rounding with our physicians. This initiative has been very successful with our pediatricians, so as you can imagine at the family birth center we have over 3,000 deliveries a year and keep quite busy. We have open medical staff, so we have many pediatric people coming in and out. Sometimes pediatric partners may have 10-12 physicians within their group, so Dr. Linnea may go round Maple Grove Hospital once a quarter.

How do we encourage a partnership between the physician, the nurse and the patient? We've encouraged physicians to push the nurse call buttons when they're rounding on the babies in the room or when they're seeing the babies in the nursery. Also including the patient in that rounding as well to say to the patients and the nurse, I'm going to go check on my other patients now, when Dr. Linnea comes in just push your call button and let me know.

Also now after a couple months, the physicians are starting to stop at our nursing stations and say, "Where's Nurse Katie? I have to go see a patient in room 2020," so together building that structure in so we're all hearing the same message. In addition to the domains here, other questions on our survey have improved around patient experience allowing consistency in messaging, so my physicians and my nurse are on the same page and also nurse to nurse the plan is communicated and I know what's happening.

Our HCAHPS scores are also regularly incorporated into our patient experience advisory team, which we help keep. How many people here have patient experience teams at hospitals? This team at Maple Grove Hospital is made up of multi-disciplinary front line staff and leadership, as well as former patients at the hospital. We have a couple of patients that call us the Hilton of Maple Grove. We've had other patients that didn't have that great experience but we wanted to incorporate their spouse's and family's experiences into some of our process improvements.

So really what this team hopes to capture is how to match the practice and improvement along with the culture? When those two things align, you really have great success around our VBP scores. Like I said, success is a combination of process improvement and culture. One example of focus on the culture is in the clinical process improvement around comfort.

Pain management is a major problem for a lot of hospitals. That question, “Was your pain well controlled during your stay and how often did the front line staff do everything they could to control your pain?” I don’t know about you, but to answer you have to do pretty well, especially if you’re a labor patient or coming through the ER in excruciating pain, meeting that expectation is a tough challenge. So we’ve empowered all our staff, whether working in housekeeping, dietary service, or whatever, to truly focus on the comfort of the patient and family.

So every interaction you have with the patient or family or anyone in the hospital, you end a conversation with “Are you comfortable?”

We created a campaign in the hospital with a button that says RUC (Are you comfortable?), and really challenge staff to make sure they’re talking with their patients about this, and that it’s used daily. Moving forward now with 2015 we again are focusing not only on comfort, but on communication. So RUC (Are you communicating?) focuses on communication and comfort.
Lastly, one thing our hospital tried in 2012 was a monetary incentive. We were fortunate enough to have been performing well financially in 2011, so in entering 2012 we tied some monetary incentives to those employees who were benefit eligible to give up to $150 quarterly based on performance of two different measures. One was overall rating, using any number between 0 and 10 “How would you rate your overall experience at the hospital during your stay?” So to get a high mark on this, patients have to answer 9 or 10.

Then our clinical measure was tied to the one question from pain management, “During your hospital stay how often was your pain well controlled?” Again, we felt that everyone in the hospital would be able to impact these measures with our comfort campaign and having ownership and pride in the overall experience of the patient.

We have met the overall rating benchmark for all four quarters in 2012, but we did not meet the pain management measure in the second or third quarter. We have met it in the first quarter so it was remarkable to see an environmental service worker or guest service representative say, “Why didn't we make that pain management goal? What were we doing?” Maybe as a security guard I could have offered someone in the emergency room a warm blanket as they needed or I could have dimmed the light, or is there music I could have been playing? Really, it was a true effort to see how everyone could impact those scores.

**Linnea Huinker:** It's really quite impressive when you have an environmental services aide come into your office and say, “I couldn't make it to my staff meeting today could you tell us how our scores are looking on this unit.” That's how involved the front line staff are. They want to know what their scores are and when they dip they want to know why they dipped and they want to know how they can bounce back up.

**Katie Potts:** So as we are getting ready now for 2015, the pie is looking a little different. We're awaiting our final reports for the 2014 year and we have some estimates out, but you have to wait for your final numbers. While we're already one month into our performance period for 2015 I think our team thought, “Oh my gosh, 2014 is over already.”

We started to introduce some new things and as we talked about earlier, the pie is looking different. So we added those efficiency measures and we have our finance manager working closely with us around that. What does cost per person look like and how can we do improvement projects around that and again being ahead of the curve. So it's January and this measure doesn't impact patients, your baseline doesn't start until June, but how can you start to be proactive around that?

Our patient care experience is staying at 30%, so again we need to make sure that patient satisfaction and experience is at the front of every process improvement. One of the things we do at Maple Grove Hospital to keep patient experience front and center is at every meeting--whether it’s finance, a staff meeting, or process improvement team--start with patient stories. We start opening up the meeting saying who has a patient story to share from the past month or week?

Sometimes patient comment cards are read. Sometimes we read comments from our NRC Picker vendor. A lot of it is cards or family stories that have been told to the managers and the front line staff where you see employees going above and beyond. We also share the reality that we didn’t do everything perfect for this patient and almost do a real time case study on why that patient’s experience wasn’t great.

It’s to ground you regarding why you come to work every day and what we’re here for. Who are our customers? They are our patients, the families, staff and employees.

Now we’ll be evaluating our performance from previous years. So, on our scorecard for quality improvement how many of you are using like a red, yellow, green indicator
to show performance? What we did this year at Maple Grove is use the VBP benchmarks and thresholds as our indicators for how you achieve a red, yellow, green. Anything below that achievement would show up as a red score on our scorecard and anything between achievement and a benchmark shows up as yellow and then anything above the benchmark is a green.

These are pretty lofty goals, especially around the HCAHPS measure, but for high performing hospitals this is a great way to challenge your front line staff and leadership. Working with another partner hospital we’ve used their baseline data as the indicator between the red and yellow. How did you perform in 2011? Then what is your stretch goal? What kind of goals have you thought for yourself that you know you can achieve above improvement points?

So they’re hopefully trying to gain points around improvement. Setting your benchmarks that way on HCAHPS as in the core measures may be a good opportunity to start incorporating VBP real time just in the hospital.

Linnea Huinker: We were going to talk about readmissions, but we’ve run out of time so if there are any questions we’ll do that so we have some time to answer a few before we’re done for today.

Katie Potts: One of the things that we do want to say and our CEO reminds us of every day is that we don’t get to be perfect all the time. With all these competing priorities it seems like you can never get above, but take a deep breath at the end of the day, acknowledge that we aren’t going to be perfect all the time but how can you keep improving and exceeding our patient and family’s expectations around the best clinical care and best patient areas.

Linnea Huinker: Our director always says over and over, it’s about culture and process. You have to have the right culture for people wanting to improve and make sure the right experiences are happening. It’s about process too because things don’t happen on their own, you have to have processes around everything. That’s our philosophy in our department.

Katie Potts: Are there any questions?

QUESTION: What is the biggest barrier to having success or having things go the way you want them to go?

A lot of the barriers I’ve seen and shifts is the buy-in from the front line staff and physicians that it’s important. So, just addressing that and why it’s important, not only from the financial dollars at risk but how is this ultimately not only going to impact CMS teams as well as other pairs. I think pay for performance is on the horizon for all pairs, and I think the dollars at risk will become greater.

And, in Hospital Compare, consumers are looking. People are getting savvy, especially a lot of the younger health care consumers that they know how to go out and navigate what this hospital is doing vs. the one down the road, and if I’m having elective surgery do I want to go somewhere where patients recommend the facilities 60% of the time or 90% of the time? Are core measures 100% or 80%?

Linnea Huinker: I just want to add that it’s always sustainment and staff exhaustion. We push a lot of them. There are always things they need to do, but that’s why it needs to be part of their work flow and process. It’s not core measures this month and pain management the next, it’s all incorporated into how they do their jobs.

A lot of it is how do we not have RUC be a phase of the month? It’s almost lasted two years now and it’s not one of those things that just last a month, it’s not a short
campaign. It’s how we do it. So, I think that’s one of our biggest barriers is simply making sure that we sustain and keep monitoring.

**Katie Potts:** I agree. I think that one of the big challenges is hardwiring the process. So you have one month, especially around HCAHPS where your scores are above the 90th percentile and you think you’ve made it, but next time they dip back down and you see this effect of up and down when you really need to step back and say we missed the boat, where did we not hardwire the process or give our staff the tools to do the same thing every time.

**How do we prioritize different initiatives that aren’t part of VBP?**

**Linnea Huinker:** We are focusing on all of them. We’re focusing on the ER measures, immunizations, etc. I will say that because immunizations isn’t a part of VBP we’re not stellar at it but we’re doing projects to improve them still. We’ve just redesigned our admission navigator to help us be better at capturing declines from the get go and reorganize the nursing process around vaccinations.

We aren’t going to focus on this one because it’s not part of VBP. Who’s to say that they aren’t going to choose it for VBP in 2017, because we know that any new measure has to be part of the measure for a year until it can be a part of VBP, so these new ones… stroke, VTE, immunizations… they could decide on the final rule any time they want it to be part of VBP. So you have to be ready and be in the forefront.

It’s funny because our ER staff think that money is tied to their measures, so I let them think that because it helps them perform better. If they want to say okay. So if they have a process and they think they have to get it done within 60 minutes to get paid, well that helps them perform better, so sometimes it’s okay if people don’t really know the truth.

Thank you everyone, we’re glad to have the opportunity to share our happy little story with you today.

**Katie Potts:** If you have any questions or want to email us offline, our information is in the packet.

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If you have any questions about this presentation, please contact Stratis Health at info@stratishealth.org.

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