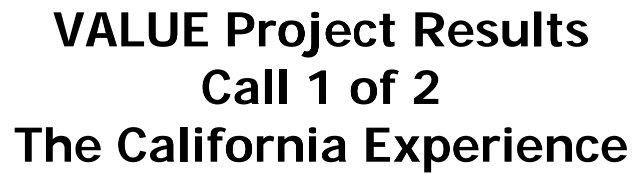
VALUE Project Results
Call 1 of 2
The California Experience



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The California Experience

The QIO Value Team

- Project Director
- Senior Scientist
- QI Consultant

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8 hospitals agreed to participate

- 2 academic facilities
- 1 large multi-service private hospital
- 4 community hospitals from a healthcare system
- 1 freestanding community hospital

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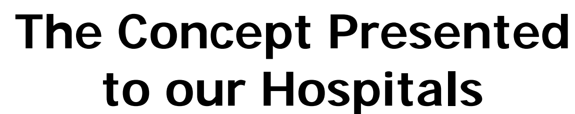

To better understand variation across hospitals:

- Employing collaboration
- With Attention to variability in processes
- Conduct rapid cycle tests of change
- Develop a peer community for QI

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Initial Provider Input

- Case Management Programs
  - hospitals described their approach, how aggressive their programs are, MD Director roles, etc. Significant variation was described
  - Intent was to have hospitals hear the initial variability and begin to think about whom they might tap for progressive ideas

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More Provider Input

Palliative Care Programs-

- Hospitals described their approach
- Palliative Care Programs are quite diverse, from non-existent to refined.
- Most hospitals indicate they have room for improvement with end of life issues

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Key Provider Input

Mortality Case Review-

- Review tool prompted areas for evaluation: ICU LOS, # comorbidities, # consults, procedures code status, Advanced Directives, PC Consults
- Although no “trends or patterns” emerged
  - Most hospitals found room for improvement in establishing code status
  - Most hospitals found at least a few cases where Palliative Care consultation (and potentially reduced utilization) was indicated

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Observations from the Data

- Hospitals that were “high utilizers” in the Dartmouth data were not necessarily high utilizers in this population data
- ICU Utilization increased dramatically between 2005 and 2007
  - Though ICU LOS did not markedly increase
- Readmissions and MD visit information included part B data, movement between multiple settings, and hospitalizations for various diagnoses
  - The level of case review needed to identify areas for focused action was considered prohibited for the term of this project

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Selected Areas of Focus

- End of Life: Palliative Care
- One Day stays: Observation
- Readmissions: Care Transitions
- ICU utilization: Alternative Settings
- MD Visits (Consults): Practice Patterns

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Process Improvement Phase

- 4 of the 8 hospitals moved into designing process improvement strategies
  - 3 of those 4 maintained that course

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Measures Designed

Process Measures:

- % of patients identified as needing family/provider meeting for whom one was accomplished by day 5
- % of ICU patients with code status established within 24 hours
- % of ICU patients with Advanced Directive or for whom surrogate decision maker was identified by day 3.
- % of patients recommended for PC services who received PC service visit or PC consult
- # of physicians allowing PC consults on their patients

Outcome Measure:

- ICU Length of Stay

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Measures Actually Used

Quite Different

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Early findings

- Use of a formal assessment scoring system for severity of illness (ie: APACHE) to identify patients likely to expire was cumbersome
- Patient/family/physician conference in ICU were very hard to coordinate
- All patients did not need a conference by day 5

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Early findings

- With or without conferences, there were some cases of misalignment between the patient/families and physician plans of care.
- MDs have various objections to "Palliative Care"
- Level of care is driven by individual physician style

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Individual Hospital Results

Hospital A:

Goal- Decrease ICU LOS and deaths in ICU.

Tests of change-

- ICU rounds with the Medical Director
- cases referred to Ethics committee.

Results-

- Overall ICU LOS was not affected
- October (baseline) found 8 deaths in ICU and in 6 of these 8 had ICU stays over 48 hours
- December (post VALUE work) found 6 deaths in ICU and 0 of these 6 had ICU stays over 48 hours

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Individual Hospital Results

Hospital E:

Goal- Increase Palliative Care Consults.

Tests of change-

- MD Education about benefits of Palliative Care
- Nurse Referral form prompts PC discussions.

Results-

- 93 Palliative Care consults house wide in November was higher than any previous month
- Nurse referrals often prompt a discussion by the attending MD or NP without a full PC Consult
- More patients are being moved out of ICU after Palliative Care Consults and discussions

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Individual Hospital Results

Hospital H:

Goal- Decrease ICU LOS and increase PC Services discussions.

Tests of change-

- CM/SW identified candidate patients and provided PC information.
- Where family requested a meeting with the MD, that request was noted in the record.

Results-

- ICU LOS change
- Number of PC Information visits

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Recommendations to CMS

- Variation analysis by location (region) did not reveal regional trends for improvement. Rather, the data only pointed individual hospitals to aspects of utilization that might be areas for improvement
- Hospital leaders agree (and their data demonstrate) that there is room for improvement in:
  - 1) Decreasing hospital length of stay, and/or
  - 2) Decreasing ICU utilization, and/or
  - 3) Decreasing readmissions, and/or
  - 4) Decreasing the number of physician visits.
- During a single scope of work, recruited hospitals should be encouraged to select one (1) of these areas to concentrate their efforts on improved utilization.

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Recommendations for QIOs

- Work with hospitals should be planned to span a 2 year period, one year is not enough time to analyze the data, and then make substantive changes.
- To maintain hospital participation, the benefit to the organization (what's in it for them)- better patient care and cost savings with reduced utilization- must be discussed up front and recalled throughout the project

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Recommendations for QIOs

- One cannot expect uniformity in processes or in contribution by hospitals within a healthcare system.
- Some improvement can be expected even when only a few key staff members can give this project some time (the Hawthorne Effect) but that improvement cannot be sustained without a system change to implement a broader internal commitment to an organized and long term approach.

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Summary Comments

- All healthcare is local
- All local healthcare is complicated
- Need to meet new people/depts/entities
- The data is powerful
  - Recruitment
  - Focusing the conversation
- Provider-driven goes best
- Perfect QIO work

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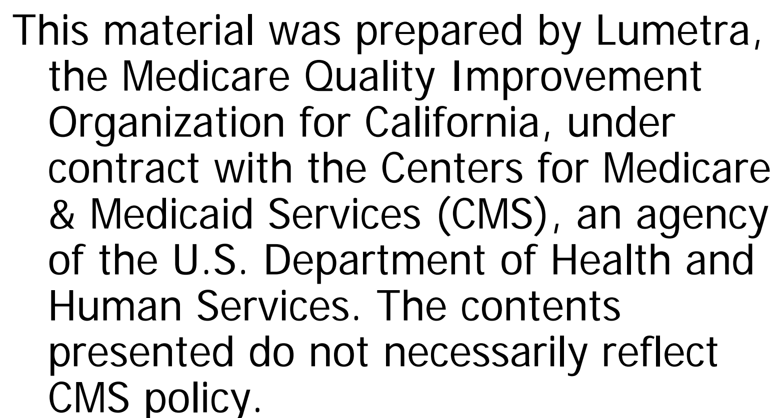

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