May 22–24, 2006 • Starr Pass Resort • Tucson, Arizona

The Next Wave: Will You Be Ready?

This session will provide an informal overview on JCAHO’s next set of regulatory requirements and other national quality improvement initiatives.

Presented by:

Vicky Mahn-DiN cola RN, MS, CPQH
Vice President & Product Manager
ACS MIDAS+
Post-Symposium Availability

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The Next Wave of Regulatory Requirements

...will you be ready?

Vicky Mahn-DiNicola RN, MS, CPQH
Vice President & Product Manager
ACS MIDAS+

More, more, more....

• More measures
• More validation
• More legislation
• More stakeholders
• More scrutiny of the measures
• More measure micro-specification work
• More alignment between JCAHO and CMS
• More maintenance and programming changes
Public Reporting: Higher Stakes

- In the beginning… Quality Improvement
- Then “consumer empowerment” through Public Reporting
- Followed by incentives for provider transparency… Pay for Reporting
- And movement to “value based purchasing”… Pay for PERFORMANCE

Slide content borrowed from Sheila H. Roman, MD, MPH, Senior Medical Officer Quality Measurement & Health Assessment Group, Centers for Medicare & Medicaid Services

UB-04 and Inpatient Perspective Payment System Changes

- UB-04 implementation March 2007
- Field locators will be revised
- File will be able to accommodate ICD-10 Diagnoses
- Expansion of number of diagnosis codes allowed on the claim
- Field locator for diagnosis status “Present or Absent on Admission”
- FY 2007 hospital specific cost weights (rather than charge based data) to adjust DRG Relative Weights
- FY 2008 proposal to refine DRG system for severity of illness
Regulatory Core Measures
Our results so far....

Adult Smoking Cessation Advice

N = 305 MIDAS+ Hospitals
Heart Failure Discharge Instructions

N = 382 MIDAS+ Hospitals

Heart Failure ACEI or ARB for LVSD

N = 378 MIDAS+ Hospitals
**Pneumococcal Vaccination**

- 30%
- 71%
- Median
- N = 383 MIDAS+ Hospitals

**Antibiotics within 4 hours arrival for Pneumonia**

- 70.4%
- 80.1%
- Median
- N = 383 MIDAS+ Hospitals
**SIP Antibiotic within 1 hour**

N = 196 MIDAS+ Hospitals

<table>
<thead>
<tr>
<th>Time</th>
<th>SIP Antibiotic within 1 hour</th>
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<tr>
<td>0%</td>
<td>70.6%</td>
</tr>
<tr>
<td>50%</td>
<td>82.9%</td>
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**Median**

**SIP Antibiotic Appropriateness**

N = 196 MIDAS+ Hospitals

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<tr>
<td>0%</td>
<td>92.9%</td>
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<tr>
<td>50%</td>
<td>94%</td>
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**Median**
**SIP Discontinuation of Antibiotics**

- N = 196 MIDAS+ Hospitals

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<td>55.4%</td>
</tr>
<tr>
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<td>72.2%</td>
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**Congestive Heart Failure Mortality**

- N = 415 MIDAS+ Hospitals

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<tr>
<td></td>
<td>4.08%</td>
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<tr>
<td></td>
<td>2.28%</td>
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</table>
**Pneumonia Mortality Rate**

N = 414 MIDAS+ Hospitals

- Median: 6.5%
- 50th: 3.6%

**Acute MI Mortality**

N = 365 MIDAS+ Hospitals

- Median: 7.96%
- 50th: 9.28%
- 7.69%
- 7.14%
New Measures To Expect

• Acute MI Mortality
  Rates 30 Days post hospital discharge

• Heart Failure Mortality
  Rate 30 Days post hospital discharge

30 Day Post Discharge
Acute MI Mortality Rates

Numerator
Patients who died of any cause within 30 days of index admission

Denominator
Medicare fee-for-service beneficiaries > 65 years discharged with principal diagnosis of Acute MI 410.xx except for 410.x2

Exclusions:
• Discharged alive with length of stay (LOS) < 1 day/not against medical advice
• Not enrolled in FFS for past 12 months
• Age < 65 years
• Episodes of care are linked across hospitals; the admission and episode are linked to the initial admitting hospital

Risk adjustment:
• Hierarchical logistic regression
30 Day Post Discharge
Heart Failure Mortality Rates

**Numerator**
Patients who died of any cause within 30 days of index admission

**Denominator**
- Medicare fee-for-service beneficiaries > 65 years discharged with principal diagnosis of Heart Failure 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.0, 428.1, 428.9

**Same exclusions and risk model as Acute MI 30 Day Mortality Rate**

✓ For multiple HF admissions, a randomly selected admission will be used. Readmissions for HF are common and without this strategy hospitals with higher readmission rates will appear to have lower mortality rates.

Appropriateness of Care Metrics

- Composite measure
- “All-or-none” measures
**Composite Metrics**

*Used in the National Hospital Quality Demonstration Project*

- Combine patient populations across topics
- Include only process measures (not outcome)
- “Process-centric”
  - Numerator: All the processes given correctly
  - Denominator: Count all the processes possible for the qualifying encounters in each topic

\[
\begin{align*}
\text{AMI Numerator} & + \text{HF Numerator} + \text{PN Numerator} = X \\
\text{AMI Denominator} & + \text{HF Denominator} + \text{PN Denominator}
\end{align*}
\]

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**8th Scope of Work Appropriate Care Measures**

*“All-or-None Metrics”*

- All or None Bundles (Measure of “Perfect Care”)
  - “Bundled processes” that relate to a specific case type
  - Optimal outcomes are achieved only when all processes are completed
  - “Patient-centric”
    - **Numerator**: All the patients that received all processes of care for which they were eligible
    - **Denominator**: Count of patients eligible for one or more process of care
**Composite vs. All-or-None Measures Impact Reporting**

**Composite Score for 10 Acute MI Patients**
- Patient #1 eligible for 8 measures (received 5)
- Patient #2 eligible for 5 measures (received 5)
- Patient #3 eligible for 2 measures (received 2)

Denominator = 15  
Numerator = 12  
Score = 80%

**All-or-None Score for 10 Acute MI Patients**
- Patient #1 eligible for 8 measures (received 5)
- Patient #2 eligible for 5 measures (received 5)
- Patient #3 eligible for 2 measures (received 2)

Denominator = 3  
Numerator = 2  
Score = 67%

---

**Heart Failure “All-or-None” Bundle**

![Graph showing the percentage of hospitals achieving the Heart Failure “All-or-None” Bundle. The x-axis represents time, and the y-axis represents the percentage of hospitals achieved. The graph shows an upward trend with 34% in the first year and 65% in the fifth year. The median line is indicated.](image-url)
**Acute MI “All or None” Bundle**

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N = 373 MIDAS+ Hospitals

**Pneumonia All or None Bundle**

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</tr>
<tr>
<td>08</td>
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<td>48.1%</td>
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N = 383 MIDAS+ Hospitals
Federal Deficit Reduction Act Requires Hospitals to Submit SIP

- Proposed ruling that all hospitals required to submit SIP measures to CMS beginning with cases discharged 1-1-06
- Proposed rule proposes a 2% reduction in Annual Payment update for non-compliance
- 196 out of 412 MIDAS+ hospitals currently collecting SIP in Q4 2005
- Public Comment Period ends of June 12th
- Final ruling expected late June 2006.
Instructions to Post a Public Comment to CMS

- [http://www.cms.hhs.gov/erulemaking](http://www.cms.hhs.gov/erulemaking)
- Click on the link "Submit electronic comments on CMS regulations with an open comment period."
- Include the caption, "Hospital Quality Data," at the beginning of your comment.
- The public comment period closes at 5 p.m. on June 12, 2006.
- To view the Federal Register notice on the proposed APU for hospitals, download or print the document at the following link and turn to page 97:
  - [http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-3629.pdf](http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-3629.pdf)

What’s on the horizon for SCIP?

**SCIP Infection Module** (begins with July 1, 2006 discharges)

- SCIP Inf-1: Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
- SCIP Inf-2: Prophylactic Antibiotic Selection for Surgical Patients
- SCIP Inf-3: Prophylactic Antibiotics Discontinued With 24 Hours After Surgery (48 for cardiac surgery)
- SCIP Inf-4: Cardiac Surgery Patients with Controlled 6AM postoperative serum glucose (<200mg/dL on POD 1 and POD2)
- SCIP Inf-5: ??
- SCIP Inf-6: Surgery Patients with Appropriate Hair Removal
- SCIP Inf-7: Colorectal Surgery Patients with Immediate Postoperative Normothermia

No option to continue collecting only the first three measures in SIP. All hospitals collecting SIP MUST transition to SCIP
SCIP Inf-4: Cardiac Surgery Patients with Controlled 6AM postoperative serum glucose

- **Why measure this?**
  - Hyperglycemia in the first 48 hours post cardiac surgery is an independent predictor of sternal infection in diabetics

- **How are we going to measure this?**
  - Measure denominator includes cardiac surgery patients regardless of history of diabetes
  - Collect the glucose value closest to 6AM draw on BOTH post-op day 1 and 2
  - Must be < 200 mg/dL both days to meet the measurement requirements for the numerator

SCIP Inf-6: Surgery Patients with Appropriate Hair Removal

- **Why measure this?**
  - Shaving the surgical site with a razor induces micro skin lacerations and disturbs the hair follicles which are often colonized with S. aureus. Patients are at greatest risk when shaved the night before.

- **How are we going to measure this?**
  - Denominator population includes over 1,200 different surgical case types! Not limited to the original SIP populations (you might want to start redesigning your pre-op check lists now!)
  - The item “Preop Hair Removal” must be answered for all qualifying patients:
    - No documented hair removal
    - Razor
    - Clippers
    - Depilatory
    - Other
    - Patient performed their own hair removal
    - Unable to determine method
SCIP Inf-7: Colorectal Surgery Patients with Immediate Postoperative Normothermia

- Why measure this?
  - Hypothermia reduces tissue oxygen tension by vasoconstriction
  - Hypothermia reduces leukocyte superoxide production.
  - Hypothermia increases bleeding and transfusion requirements
  - Hypothermia increases adverse cardiac events
  - Hypothermia increases duration of hospital stay even in uninfected patients

- How are we going to measure this?
  - Normothermia is defined as a temperature of 96.8 to 100.4 within the first hour after leaving the operating room
  - Actual values for temperature must be recorded
  - Any mode of temperature collection is accepted e.g. axillary, rectal, tympanic, bladder probe, rectal, oral

SCIP Cardiac and SCIP VTE Measures Planned for October 1, 2006

- SCIP Card-1: ??
- SCIP Card-2: Surgery patients on beta blocker therapy who received a beta blocker during the peri-operative period
- SCIP VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis ordered any time during admission
- SCIP VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to Surgical to 24 hours after surgery
**SCIP – Respiratory Complication Prevention**

- Implementation delayed until JCAHO and CMS consensus is achieved
- Anticipated that this module will cover Ventilator Associated Pneumonia (VAP) population
- No timeline yet published

**SCIP QIO 8th Scope of Work Baseline Survey**

- 526 participant hospitals identified across all states
- 1st quarter 2005 discharges
- Infection and VTE modules only
- Medicare beneficiaries only
- CDAC to conduct the data abstraction for baseline survey (not hospital submitted data)
- Approximately 85 charts per hospital may be requested early in June 2006 if your hospital has been identified
SCIP QIO 8th Scope of Work Plans for re-measurement in 2007

• Identified participant group that participated in the baseline study will be required to collect and submit SCIP data (either Q4 2006 or Q1 2007 discharges – yet to be determined)
• Analysis will be conducted to assess for differences in Medicare and non-Medicare rates
• SCIP infection and VTE modules only

MIDAS+ Plans for Supporting SCIP

• Mid-August overlay to contain new SCIP Focus Study and Worklist for collecting all measures in the SCIP data set
• Mid-August overlay to contain profile of measures for SCIP 1, 2, 3, 4, 6 and 7
• Mid-November overlay to contain profile of measures for SCIP Cardiac and DVT
• SIP Focus study and SIP measures to be retired for encounters discharged July 1 2006 forward
• WebEx Training Sessions for data abstraction of SCIP to start in August
**10 VTE Measures in Alpha Test Summer 2006 (55 hospitals)**

**Risk Assessment/Prevention**
1. Documentation of Venous Thromboembolism Risk Assessment (RA)/Prophylaxis within 24 Hours of Hospital Admission
2. Documentation of Venous Thromboembolism Risk Assessment (RA)/Prophylaxis within 24 Hours of Transfer to ICU

**Treatment**
3. Documentation of Inferior Vena Cava Filter Indication
4. Venous Thromboembolism Patients with Overlap of Parenteral and Warfarin Anticoagulation Therapy
5. Venous Thromboembolism Patients Receiving Unfractionated Heparin with Platelet Count Monitoring
6. Venous Thromboembolism Patients with Renal Insufficiency that Received Reduced/Discontinued Anticoagulation Therapy
7. Venous Thromboembolism Patients Receiving Unfractionated Heparin Management by Nomogram/Protocol
8. Venous Thromboembolism Discharge Instructions

**Outcome**
9. Venous Thromboembolism Patients with International Normalized Ratio > 6 After Initiation of Warfarin Therapy
10. Incidence of Potentially Preventable Hospital-Acquired Venous Thromboembolism

There will be a “Call for Hospitals” posted on JCAHO Web site in September 2006 to invite interested facilities to pilot test the measures in early 2007. Topic tentatively scheduled to roll out as another Core Measure Topic in 2007.
Hospital Based Inpatient Psychiatric Services Test Measures (HBIPS)

- HBIPS 1: Assessment of risk, substance abuse, trauma and patient strengths completed
- HBIPS 2: Patient perception of treatment experience
- HBIPS 3: Hours of restraint use
- HBIPS 4: Hours of seclusion use
- HBIPS 5: Patients discharged on multiple psychiatric medications
- HBIPS 6: Discharge assessment and aftercare recommendations are provided to community health providers upon discharge

Hospital Based Inpatient Psychiatric Services Test Measures (HBIPS)

- Final specifications for test measures to be completed June 2006
- Specifications to PMS vendors by September 2006
- Anticipate pilot test set data collection to begin January 1, 2007
- Psychiatric hospitals will have the OPTION of collecting and submitting HBIPS Test Measures to JCAHO in lieu of 9 psychiatric ORXY® measures
- Acute care hospitals can NOT use these as one of their three Core Measure topics YET
- No public reporting yet…THIS IS A TEST
Children's Asthma Candidate Core Measure Set

- Use of Relievers for Inpatient Asthma (NQF-endorsed Voluntary Consensus Standard for Hospital Care)
- Use of Systemic Corticosteroids for Inpatient Asthma (NQF-endorsed Voluntary Consensus Standard for Hospital Care)
- Home Management Plan of Care Given to Patient/Caregiver
- It is anticipated that data collection may commence as early as 2007

Hospital Consumer Assessment Health Plan Satisfaction (Hospital CAHPS®)

- HCAHPS contains 27 items
  - 22 Core Questions
  - 5 demographic questions
- Measure Domains
  - Nurse communication (3)
  - Doctor communication (3)
  - Cleanliness and quiet of hospital environment (2)
  - Responsiveness of hospital staff (2)
  - Pain management (2)
  - Communication about medicines (2)
  - Discharge Information (2)
- Overall rating of hospital (Question 21)
- Willingness to Recommend Hospital (Question 22)
National Implementation Timeline for H CAHPS®

- **Dry run**
  - Approved participation form
  - Registered with QualityNet Exchange
  - Patient discharges from April, May and/or June 2006
  - Data collection ends September 2006
  - No public reporting

- **Initial Wave**
  - Patient discharges from Q4 2006
  - Data collection ends March 2007
  - Data submission to QNET April 2007
  - First public reporting late 2007

National Implementation Strategy for H CAHPS®

- **Hospitals can contract with vendors to conduct survey and submit data to QNET**
  - ACS MIDAS+ is NOT a HCAHPS vendor at this time however we will work with clients to create an inbound interface from your vendor to MIDAS+ to support integrated reporting

- **Hospitals can conduct the survey themselves and submit data to QNET**
  - Request using HCAHP survey at www://hcahpsonline.org
  - Mandatory training required
  - Survey modes include:
    - Mail only
    - Telephone only
    - Mixed Mail and Telephone
    - Active Interactive Voice Response Systems
### HCAHPS® Telephone Survey Methods

- **Telephone Survey**
  - Initiate contact to sampled patients between 48 hours and six weeks after discharge.
  - Must attempt at least five calls at different times of the day, on different days of the week, and in different weeks within 42 days after initiation.
  - One phone call attempt = six rings with no answer.
  - When busy signal is reached call up to three times at 20 minute intervals (equals one phone call attempt).
  - Cannot interview “proxy” respondents if patient is not available or can’t understand the survey.
  - Telephone script for HCAHPS is provided.
  - Interviewers must go through training.

### HCAHPS® Mail Survey Methods

- **Mail Survey**
  - Questionnaires sent with cover letter to sampled patients between 48 hours and six weeks after discharge.
  - Second questionnaire sent with reminder to non-respondents within 21 days after initial mailing.
  - Complete data collection within 21 days after the second mailing.
  - Must include self-addressed, stamped business return envelopes.
  - Must be mailed with first class postage.
**Hospital Consumer Assessment Health Plan Satisfaction (Hospital CAHPS®)**

**Eligible Population Criteria**
- 18 years or older at time of admission
- Admission includes at least one overnight stay in hospital
- Non-psychiatric principal diagnosis at discharge
- All payer types are eligible for survey

**Patients who will be excluded**
- Patients who expire
- Any other groups defined by STATE regulations as being excluded from survey
- For patients with multiple hospital stays within the same month, only 1 encounter per month to be included in sample

**Hospital CAHPS® Sampling Methodology**

- Simple random sample from each month in the reporting period
- 300 completed questionnaires must be submitted to QNET over the reporting period (initial wave to be a nine month reporting period, thereafter it will be a 12 month reporting period)
- Expected response rate of eligible patients estimated to be about 40% but can vary by mode of survey administration
Calculating the number of discharges needed to produce 300 completed HCAHPS® Surveys

\[
P = (1 - I) \times R \\
N = \frac{C}{P}
\]

- C = number of completed surveys required (300 during reporting period)
- I = expected proportion of discharged patients who are ineligible (national statistics suggest this is 17%)
- R = expected survey response rate (national statistics suggest this is 40%)
- P = Proportion of discharged patients expected to complete the survey
- N = Number of discharges to be sampled over reporting period

\[
P = (1 - .17) \times .40 = .33 \\
N = \frac{300}{.33} = 909
\]

909/9 months = 101 discharges per month to survey for 9 month period
909/12 months = 75 discharges per month for 12 month period

Additional National Collaborative Measurement Activities

- Leapfrog Hospital Rewards Program
- IHI Save 100K Lives
- Ambulatory Care Quality Alliance
- Physician Voluntary Reporting Program
**Leapfrog Hospital Rewards Program**

- Focused clinical areas were chosen to maximize commercial employer impact
- **Concept of Reward principles**
  - Top performers will get increased market share through patient shift
  - “Rewards” will kick in after second consecutive reporting of sustained improvement
  - “Bonuses” are paid based on plan/purchaser average cost of top cohort hospitals
    - 2% for Top Performance
    - 1.25% for improving from Cohort 3 to Cohort 2
    - 0.50% for improving from Cohort 4 to Cohort 3

**Requirements for Leapfrog Hospital Rewards**

- **Completion of Leapfrog Group Hospital Quality and Safety Survey**
  - Organization and contact information
  - Computer Physician Order Entry (CPOE)
  - Evidence based hospital referral (EHR)
  - ICU Physician Staffing
  - National Quality Forum Safe Practices (30)
- **Submission of efficiency measures**
- **Submission of effectiveness measures**
**Leapfrog Hospital Rewards Program**

- **Measures of efficiency (14)**
  - Actual LOS (routine and special care*)
  - Severity adjusted LOS (routine and special care*)
  - Readmission rates within 14 days (any condition)
  - Computed for AMI, PCI, Pneumonia, CABG and Routine Delivery

* Requires Routine and Special Care Room Accommodation Type Code and Days to be captured from your billing and claims data

- **Measures of effectiveness**
  - JCAHO Core Acute MI Measures
  - JCAHO Core SIP Measures
  - JCAHO Core Pneumonia Measures
  - JCAHO Core Pregnancy Related Conditions

- **Submitted to Leapfrog via existing Core Measure Vendors**
**IHI Save 100K Lives**

- **Initiatives include:**
  - Deployment of Rapid Response Teams
  - Preventing Adverse Drug Events
  - Delivery of reliable, evidenced-based care for Acute MI Care
  - Prevention of Surgical Site Infections
  - Prevention of Central Line Infections
  - Prevention of Ventilator Associated Pneumonia
- Number of Lives Saved to be announced June 14th at the 2nd Annual International Summit on Redesigning Hospital Care in Atlanta
- Ongoing efforts to accelerate improvement in 2006-2007
- New initiatives to be identified
- IHI will continue to receive mortality rate, Acute MI and SIP data from hospitals throughout 2006 and possibly beyond

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**How Lives Saved Are Calculated**

- Calculation method based on changes in acute care inpatient mortality within each hospital over time
- Hospital’s 2004 mortality counts by month are compared to mortality counts by month in 2005 (adjusted for acuity using case mix index)
- Lives saved calculation looses statistical power when applied at the hospital level as compared to the campaign level
- Intervention level measures better for capturing impact of campaign endorsed interventions

### IHI Data Transmission

- 115 MIDAS+ hospitals submitting data to IHI via MIDAS+
- MIDAS+ data warehouse opens for Q1 2006 data on May 22nd to accommodate early transmission for IHI sites
- All Q1 2006 data files are due to MIDAS+ no later than June 3rd if they are going to be included in the IHI Number of Lives Saved Analysis for June 14th Announcement
- Data not received by MIDAS+ by June 3rd will still be accepted anytime by June 21st. Data will be sent to IHI but not included in the initial IHI Save 100K Lives calculation.
- IHI Transmission for IHI Mortality Rate and AMI and SIP Intervention measures to continue until the end of 2006 and possibly beyond.
- No charge for MIDAS+ submission to IHI

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### Table: IHI Data Transmission

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**Total Lives Saved** 36.45
**Ambulatory Care Quality Alliance**

- A broad based national coalition of 125 member organizations
- Objective is to develop a common set of measures for public reporting and P4P
- AHRQ and CMS currently sponsoring a pilot project

**Ambulatory Care Starter Measure Set**

- Breast and colorectal screening
- Tobacco use and counseling
- Influenza and pneumococcal vaccination
- CAD Drug Therapy
- HF assessment and therapy
- DM monitoring and management
- Asthma identification and management
- Depression diagnosed and treated for 6 months
- Prenatal care
- Appropriate testing and treatment for children with URIs
Physician Voluntary Reporting Program

- ASA at arrival for AMI
- Beta Blocker at arrival for AMI
- HgbA1C control in DM
- HBP control in DM
- ACE/ARB for LVSD
- Beta Blocker for Hx of Acute MI
- Fall Assessment in the elderly
- Antidepressants for depression
- Dialysis dose in ESRD
- Hct level in ESRD
- Receipt of AVF in ESRD on dialysis
- Antibiotic prophylaxis for surgery
- VTE prophylaxis in surgical patients
- IMA use in CABG patients
- Pre-op beta blocker for isolated CABG

Physician Voluntary Reporting Program

- Began January 2006 (voluntary)
- Small number of physician practice groups are participating
- Specialty societies are driving interest in participation
- Data collection infrastructure in development
- Participants get feedback on 16 Quality Measures
The Impact of Measurement...

I went to the doctor for my yearly physical. His nurse starts with certain basics.

How much do you weigh?” she asks.
"115," I say. The nurse puts me on the scale. It turns out my weight is 140.

The nurse asks, "Your height?" "5 foot 8," I say.
The nurse checks and sees that I only measure 5’ 5”.

She then takes my blood pressure and tells me it is very high.

"Of course it’s high!" I scream, "When I came in here I was tall and slender! Now I’m short and fat!"

The doctor put me on Prozac.