Quality Council Minutes
Internal Medicine Quality and Innovation Program
June 21, 2016, 5:30-7:00 pm
Dining Rooms C and D, University Hospital

Meeting Objective
• Review current division work and define opportunities to collaborate
• Obtain feedback re Departmental QI activities
• Learn about quality work from council members

Council Members
• Christine Holland – Allergy and Immunology
• Kim Eagle – Cardiovascular Medicine*
• Grace Elta – Gastroenterology *
• Mike Rice – Gastroenterology *
• Rob Ernst – General Medicine
• Jeff Rohde – General Medicine*
• Lillian Min – Geriatric Medicine*
• David Smith – Hematology and Oncology *
• Dale Bixby – Hematology and Oncology *
• Kevin Gregg – Infectious Diseases
• Jennifer Wyckoff – Metabolism, Endocrinology, and Diabetes*
• Craig Jaffe – Metabolism, Endocrinology, and Diabetes
• Eric Fearon – Molecular Medicine and Genetics *
• Elena Stoffel – Molecular Medicine and Genetics*
• Jonathan Segal – Nephrology *
• Rommel Sagana – Pulmonary and Critical Care
• Tim Laing – Rheumatology
• Puja Khanna – Rheumatology*
• Tim Hofer – VA *
• Nate Houchens - VA
• Chris Petrilli – Resident Representative*
• Daniel Alyesh – Fellow Representative
• Diane Drago – Patient Representative
• Anita Devine – Patient Representative

Quality and Innovation Program Team
• Scott Flanders – Council Chair
• Jim Froehlich
• Maria Han
• Tammy Ellies

Guests
• Katie Schwalm
• Absence

Slides available on:  http://www.med.umich.edu/intmed/about/quality.htm
<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Action Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>5:30 – 5:40</td>
<td><strong>Welcome and agenda review</strong> Welcome to new council members Rob Ernst and Nate Houchens.</td>
<td></td>
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</tbody>
</table>
| 5:40 – 5:45 | **CVM Value Challenge (Slides attached) – Dan Alyesh** The program is modeled after a similar concept at UCSF. It will kick off on August 22, 2016 with the idea generation phase. They are still looking for patient advisors. Questions and discussion points:  
  - What is the incentive for faculty to take on extra work for these projects? Will there be protected time? Right now there are prizes for idea submission and a $100k grand prize if the idea is selected as a project. Criteria is being developed for how the money can be used. The CVC has committed resources for coordination and measurement. Funding for protected time is unclear. There was discussion that even without formal protected time, there will need to be acknowledgement from leadership that faculty and staff will be provided with time to work on the project if selected.  
  - Who can submit ideas? Anyone – faculty or staff – can submit.  
  - To measure value improvement, quality and cost need to be considered. How will cost data be obtained? This is being discussed and was noted as an important consideration.  
  - It is important to track results over time to see if the improvements and returns are sustained. How long will results be tracked? 6-12 months is the current plan.  
  - How many projects did UCSF take on? They had 120 ideas the first year and 70 in the 2nd and 3rd years. They chose to take 3 simpler projects in the first year, and then expanded to more complex projects after that. UM has chosen to limit the amount of projects in the first year (targeting one project).  
  Tammy will connect Anita and Diane to Dan for possible involvement as patient advisors.  
  Dan will be in contact about future opportunities including an advisory group, proposal submissions, how to interact online during the crowd-sourcing phase, etc. |
| 5:45 – 6:05 | **Project updates - Atrial Fibrillation (slides attached)** Phase 1 of the project focused on the development of a clinical pathway for care in the ED and a rapid follow up clinic for patients that don’t need to be admitted. Both interventions were successful. A dashboard has been created to continue to monitor this patient population. The next part of the project will focus on inpatient care for patients with Afib. Questions and discussion points:  
  - Was a Cardiology consult service for the ED considered? Through the development |
<table>
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<tr>
<td></td>
<td>and use of the standard pathway for ED care of patients with Afib, a consult service was not needed. Patients receive cardioversion if needed from the ED physician and are then discharged with follow up in the clinic. • Will the project look at patients with Afib who are not on anti-coagulants? The team is interested in this.</td>
<td></td>
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<tr>
<td>6:05 – 6:25</td>
<td><strong>Division Update - Pulmonary and Critical Care Medicine – Rommel Sagana (slides attached)</strong> Three projects were highlighted: A fellows project looking at bronchoscopy complication rates, the transitional care management clinic for COPD, and a physician based value model for evaluating physicians.</td>
<td>Provide contact for PACE data questions.</td>
</tr>
<tr>
<td>6:25 – 6:50</td>
<td><strong>Program updates</strong> • Ford Quality visit – Last year, a small group of UMHS leaders attended the Ford Quality meeting, where leaders from Ford global operating units report in on their business metrics in a standard format. If there is interest, we will set up a visit for the fall. • Data o The UMMG is asking for feedback on the internal pay for performance quality measures to be used for FY17. The deadline for feedback is July 15. o We will be conducting a joint survey with Steve Bernstein to assess quality data flowing in and out of divisions. For example, who is reporting data and where does it come from? Who is receiving data? • QI Team – We ran out of time to discuss • Education– We ran out of time to discuss • Dashboards – We ran out of time to discuss</td>
<td>We will gauge interest and let the council know about possible dates. We will forward the UMMG email with details to the group. Discussion at next meeting.</td>
</tr>
<tr>
<td>6:50 – 7:00</td>
<td><strong>Wrap Up and Next steps</strong> Please note that our goal is to have at least one council member in attendance from each division. <strong>Next Meetings:</strong> • September 20, 2016, 5:30-7:00 pm, 3201 Taubman Center • December 12, 2016, 5:30-7:00 pm, 3201 Taubman Center</td>
<td>If you cannot attend future meetings, please send an alternate in your place. Thank you.</td>
</tr>
</tbody>
</table>
The Frankel CVC Value Innovation Challenge

Harvesting ideas for change in an engaging and novel way
What is value in health care?

- Providers must lead the way

Value = Quality / Cost

Porter ME, and Lee TH. HBR, 2012
Overview

**Idea Harvesting**
- Virtual suggestion box

**Wiki optimization**
- Proposal submission
- Crowd-sourced proposal improvement

**Idea Selection**
- “Shark tank” review
- Select one idea

**Sustainability**
- Funded idea is supported through infrastructure, etc...
Benchmarked with peer institutions

UCSF Center for Healthcare Value

CARING WISELY

Costs of Care

Penn Medicine

Center for Health Care Innovation
Accelerating Ideas to Transform Health Care
Version 1.0

• No more Nebs after 24-hours

• Reduction of RBC transfusions

• IV to PO Abx
Evolution of successes

Care Management for VAD Patients

Reducing Epic Data Entry Time

- Operating Wisely: Reducing Operating Room Turnover Times at UCSF submitted by Lindsay Hampson and team members Peter Carroll, Maxwell Meng, Matthew Cooperberg, Michael Gropper, Errol Lobo, and Lauren Aichele (UCSF Health System);

- Merged proposals: Perioperative Utilization Data Review submitted by Kent Soo Hoo and team members Andy Goldberg, Kevin Bozic, Kevin Pattison, and Sandy Weinholz; and Reducing Operating Room Costs through a Price Transparency Initiative submitted by Corinna Zygiourakis (UCSF Health System);
The team, the team, the team

- Daniel Alyesh, MD - Chief Fellow, Cardiology
- Jamie Beach, RN - Quality Data Manager
- Lauren Heidemann, MD - HO Quality Council Chair
- Andrea Obi, MD - Fellow, Vascular Surgery
- Shelley Lassey, RN - CVC Clinic Nurse
- Chris Petrilli, MD - Chief Medical Resident
- Vikram Sood, MD - Fellow, Cardiac Surgery
- Nikki Taylor, RN - Clinical Nurse Specialist
- Kelsey Flynt, MD - Chief Radiology Resident
- Ran Lee, MD - Cardiology Fellow
- Seeking Patient/family advisor
Advisory group

• Frontline employees
• Mid and high-level leadership
• Quality council leaders and members
• Patient and family member representatives
Overall timeline

• Kickoff: **August 22, 2016**
• Phase 1: Idea harvesting (2-4 weeks)
• Phase 2
  – Call for proposals (2-4 weeks)
  – Community optimization (4-6 weeks)
  – Determination of finalists (1 week post optimization)
• Phase 3
  – Selection contest (1 day) **November 17, 2016**
• Phase 4: Sustainability and Spread (6 months to one year)
Idea harvesting

- Virtual suggestion box to improve value of care
- Communication at all levels
- Maximize ideas
- Minimize barriers to submission
  - 50 words or fewer
  - Anyone can submit
- Use crowd source platform
Call for proposals

• Ideally targeting top ideas from Phase 1
• Integrated online submission platform
  – UMHS password protected
• 400 words or fewer
Submission guidelines

• Proposals to improve value of care at the CVC
  – Improve the quality of care
    • IOM definition: safety, efficacy, timeliness, efficiency, patient centeredness, equitability
  – Improve the cost of care
  – Promote interprofessional collaboration
Community optimization

- Open proposal platform
- “Wiki optimization”
- Online members comment on and promote proposals
- Patient and family member participation
- Synergistic efforts and matchmaking
Creating an open proposals platform

**Improving Ideas Together**

**UCSF Open Proposals**

1. **Share Your Idea Online**
   - Open Submission Phase
   - Proposal Author: Eligible community member open to sharing his/her idea
   - We were surprised to hear from people we didn't even know about!

2. **Crowdsourcing to Improve Proposals**
   - Open Improvement Phase
   - Ideas Are Enriched By the Community
     - Ask questions, offer support, and give suggestions
   - Teams Grow and Strengthen
     - Find collaborators
   - Improve and Resubmit Proposals

3. **Review and Award Phases**
   - UCSF Open Proposals helped us select the best idea in a transparent way.

**Traditional Approach**

- Missed Opportunities for Collaborating
- Redundant Proposals
- No Opportunity for Input/Feedback

**Samuel and Jean Frankel Cardiovascular Center**

**University of Michigan Health System**
Determination of finalists

- Selection within 1 week of optimization end
- Based upon:
  - Demonstrated commitment and engagement of clinical leadership and frontline staff
  - Potential to scale
  - Promotion of interprofessional collaboration
- Up to five finalist projects
Selection contest

• Think “Shark Tank”
• 10 minute “pitches” with brief Q&A
• Expert judges
• Audience of faculty, staff, trainees, patients and families
• Winner(s) selected at the end of the session
Sustainability and Spread

- CVC will support winner with
  - Funding
  - Infrastructure support
  - Regular “works in progress” meetings
  - Continued publicity
Overall timeline

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• Phase 4: Sustainability and Spread (6 months to one year)
Current Barriers

- Different schedules
- Silos / Duplicative efforts
- Minimal cross discipline communication
- Lack of infrastructure
- Bureaucracy / Politics
Advisory Group

- Frontline employees
- Mid and high-level leadership
- Quality council leaders and members
- Patient and family member representatives
Atrial Fibrillation ED Process Improvement Update

6/3/2016
Overview

• Background
• Current State
• Future State
• Intervention
• Experience and Data
• Clinical Design Afib ED Dashboard
• Progress and Next Steps
Background

• Atrial fibrillation (AF)
  – Multidisciplinary/multifaceted care
  – Diagnostic testing (e.g., labs, echocardiogram)
  – Control heart rate and symptoms, cardioversion, and anticoagulation.

• Hospital admission is default to coordinate care
  – Inefficient
  – Short admissions without definitive care
  – Long delay to ultimate referral
  – Delays in achieving milestones of care
Current State Challenges

• Unnecessary admissions
  – Uncertainty regarding anticoagulation decision and agent choice
  – Access to outpatient follow up—admission to consult
  – Discharge criteria not clear/standardized

• No clarified guiding algorithm of care
  – Infrequent use DCC cardioversion in ED
  – Secondary driver of atrial fibrillation not always identified
Current State

Project Value Stream Map Current State

AFIB ED
January 11, 2016
Future State

Project Value Stream Map Future State

**AFIB ED**
January 13, 2016
Future State

AF/AFL Clinical Pathway

Examples of reversible causes of secondary drivers of AF:
- Ischemia
- Hypertension
- Acidosis
- Anemia
- Hyperthyroidism
- Hypercalcemia
- Alcohol
- Drug (e.g., beta-blockers, digoxin, amiodarone)
- Pericarditis
- Hypocalcemia
- Hypokalemia
- Hypomagnesemia
- Hypothyroidism
- Thyrotoxicosis
- valve disease (e.g., mitral valve prolapse)
- Structural heart disease
- ECT

Criteria for ED catheter ablation:
- AF is not recurrent (not chronic)
- AF symptom onset > 60 days
- Effective anticoagulation for at least 3 weeks
- No evidence of acute cardiac ischemia, decompressed CHF, or clear reversible cause identified
- No prior unsuccessful ICD attempts
- No contraindication to procedural sedation

Criteria for ED discharge:
- Patient returns to NSR and symptoms resolve OR
- Patient remains in AF but meets these criteria:
  - Symptomatic
  - HR in acceptable range
  - Presence of comorbidities (e.g., hypertension, diabetes, CHF)
  - Hemodynamic stability, including tolerance of rate control medications
  - Rapid follow-up is feasible (follow-up is available, and patient is able to attend)

Follow-up checklist:
- Patient has been given appointment in rapid follow-up clinic within 48 hours
- Patient education and follow-up provided

(Note: Anticoagulation should not be initiated in the ED. Rather, this will be initiated in the rapid follow-up clinic)
Intervention

• **Create Rapid AF Follow-Up Clinic:** appointment within 72 hours of ED discharge.
  – No need for perfect rate control in the ED
  – No need to initiate anticoagulation in the ED
  – It facilitates attempts at cardioversion in the ED for selected patients

• **Create AF/AFL Clinical Pathway**
  – Discharge criteria clear
  – Establish candidacy for DC Cardioversion
  – Simplify drug selection/avoid IV medications

• **Anticipated effects**
  – Decrease admission rate
  – Increase DCC utilization
  – Shorten the time from AF onset to the provision of specialty care.
Experience and Data

- Since late January 2016, test of the Rapid AF Follow-Up Clinic.
  - 16 patients have been sent to the clinic.
  - Approximately 8 (50%) would have likely been admitted
  - Feedback from ED, EP (in follow-up), and patients very positive.

- In a retrospective chart review: need ~5-9 clinic spots per week
Experience and Data

• Algorithm for patient treatment pathway:
  – Identify candidates for ED cardioversion with discharge and follow-up.
  – Identify candidates for oral rate-control.
  – Defer the decision for anticoagulation to the follow-up clinic

• Since piloting the rapid follow-up clinic for patients presenting to the ED with Afib, it has been identified many of our Afib patients can be safely and appropriately cared for in the outpatient setting.
Clinical Design Afib ED Dashboard

- MiChart & PACE representatives developed a data dashboard to track and measure progress on an ongoing basis.
- Work in progress. The goal is to have the data and measures available via MiChart on a real-time basis.
- The dashboard will be filterable and interactive.
- The next slide is an example of what a portion of the dashboard will show.
Progress and Next Steps

- Received approval for AF Rapid Follow-Up Clinic with 0.5 FTE in incremental NP/PA staffing to support this bridge clinic.
- Continue pilot as appointment slots are scheduled through August.
- Ramp up EP follow-up clinic with new hire (? Q3-Q4 16).
- Next Project: Inpatient Care
  - Clinical pathway for patients admitted through the ED with AF.
  - Studying current state inpatient processes
  - Develop clinical pathway algorithm to create a standardized approach and reduce variation and lag times within the inpatient stay.
Quality Improvement in Pulmonary & Critical Care

Rommel Sagana, M.D.

6/21/16
19th century obstetrician Ignaz Semmelweis
High # of complications in 6 month period -- UofM – January 2012 to June 2012

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Complication Rate</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;severe lung disease&quot;</td>
<td>20%</td>
<td>90</td>
</tr>
<tr>
<td>mean FEV1 38%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Normal to moderately severe lung disease
N = 472

![Graph showing total complication rate for different categories](Graph.png)
<table>
<thead>
<tr>
<th>Complication Counts</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Major Complications</td>
<td>54</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>16</td>
</tr>
<tr>
<td>Bleeding &gt; 50ml</td>
<td>44</td>
</tr>
<tr>
<td>Respiratory Failure</td>
<td>8</td>
</tr>
<tr>
<td>Higher Level of Care</td>
<td>32</td>
</tr>
<tr>
<td>Admission</td>
<td>24</td>
</tr>
<tr>
<td>ICU Admission</td>
<td>15</td>
</tr>
<tr>
<td>Major Complication or Higher Level of Care</td>
<td>70</td>
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<tr>
<td>Total</td>
<td>70</td>
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</table>
## Univariable Analysis Predicting a Complication

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>OR</th>
<th>p</th>
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<tbody>
<tr>
<td>Age ≥ 65</td>
<td>1.40</td>
<td>0.17</td>
</tr>
<tr>
<td>FEV1</td>
<td>0.99</td>
<td>0.18</td>
</tr>
<tr>
<td>FVC</td>
<td>0.99</td>
<td>0.17</td>
</tr>
<tr>
<td>DLCO</td>
<td>0.99</td>
<td>0.36</td>
</tr>
<tr>
<td>Restriction</td>
<td>1.31</td>
<td>0.29</td>
</tr>
<tr>
<td>Obstruction</td>
<td>1.29</td>
<td>0.34</td>
</tr>
<tr>
<td>Baseline O2</td>
<td>0.75</td>
<td>0.59</td>
</tr>
<tr>
<td>Acute O2 &gt; Baseline</td>
<td>2.76</td>
<td>&lt;0.01</td>
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<tr>
<td>Wheeze</td>
<td>1.09</td>
<td>0.89</td>
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<tr>
<td>Inpatient</td>
<td>0.88</td>
<td>0.625</td>
</tr>
<tr>
<td>Transplant</td>
<td>2.84</td>
<td>&lt;0.01</td>
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<tr>
<td>Volume</td>
<td>0.99</td>
<td>0.28</td>
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<tr>
<td>Residual</td>
<td>0.99</td>
<td>0.10</td>
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<tr>
<td>TBBx</td>
<td>3.14</td>
<td>&lt;0.01</td>
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<tr>
<td>BxPasses</td>
<td>0.96</td>
<td>0.44</td>
</tr>
<tr>
<td>EBUS</td>
<td>0.37</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>SuperD</td>
<td>1.03</td>
<td>0.936</td>
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</table>

## Multivariable Logistic Regression Predicting a Complication (Bootstrap Estimation)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>aOR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 65</td>
<td>1.88</td>
<td>1.12, 3.14</td>
<td>0.02</td>
</tr>
<tr>
<td>O2 &gt; Baseline</td>
<td>3.70</td>
<td>1.88, 7.27</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Transplant</td>
<td>2.09</td>
<td>1.19, 3.67</td>
<td>0.01</td>
</tr>
<tr>
<td>TBBx</td>
<td>3.05</td>
<td>1.71, 5.42</td>
<td>&lt;0.01</td>
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</tbody>
</table>

Model diagnostics: c-statistic: 0.72, HL goodness-of-fit p = 0.89
### Predicted Probabilities of a Complication

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No</th>
<th>Yes</th>
<th>Margin</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 65</td>
<td>7.3%</td>
<td>12.4%</td>
<td>5.1%</td>
<td>0.02</td>
</tr>
<tr>
<td>O2 &gt; Baseline</td>
<td>7.5%</td>
<td>21.4%</td>
<td>13.9%</td>
<td>0.03</td>
</tr>
<tr>
<td>Transplant</td>
<td>6.5%</td>
<td>12.3%</td>
<td>5.8%</td>
<td>0.14</td>
</tr>
<tr>
<td>TBBx</td>
<td>5.1%</td>
<td>13.4%</td>
<td>8.4%</td>
<td>&lt;0.01</td>
</tr>
</tbody>
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### Points

<table>
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<th>Points</th>
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<tbody>
<tr>
<td>Age ≥ 65</td>
<td>2</td>
</tr>
<tr>
<td>O2 &gt; Baseline</td>
<td>6</td>
</tr>
<tr>
<td>Transplant</td>
<td>2</td>
</tr>
<tr>
<td>TBBx</td>
<td>3</td>
</tr>
</tbody>
</table>
## Retrospective Data Collection

- Patients with risk score ≥ 6 subjected to chart review

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Outcomes:</th>
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</thead>
<tbody>
<tr>
<td>Patient Type</td>
<td>Pneumothorax</td>
</tr>
<tr>
<td>Indication for Bronchoscopy</td>
<td>Chest tube needed?</td>
</tr>
<tr>
<td>Positive pre-bronchoscopy culture?</td>
<td>Bleeding &gt; 50mL</td>
</tr>
<tr>
<td></td>
<td>Respiratory Failure Requiring Intubation</td>
</tr>
<tr>
<td></td>
<td>Unplanned ward admission</td>
</tr>
<tr>
<td></td>
<td>Unplanned ICU admission</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Positive BAL Culture</th>
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</thead>
<tbody>
<tr>
<td>BAL agreement with pre-bronch sputum?</td>
</tr>
<tr>
<td>BAL non-infectious diagnosis made?</td>
</tr>
<tr>
<td>Tbbx diagnostic of rejection?</td>
</tr>
<tr>
<td>Tbbx diagnostic of other diagnosis?</td>
</tr>
<tr>
<td>Antimicrobials changed?</td>
</tr>
<tr>
<td>Other treatment changed?</td>
</tr>
<tr>
<td>Malignancy diagnosed?</td>
</tr>
<tr>
<td>Did bronch aid final clinical diagnosis?</td>
</tr>
<tr>
<td>Did bronch change management?</td>
</tr>
</tbody>
</table>
Risk highest in inpatients, transplant, and immunosuppressed
\[\rightarrow\] inpatient consent changed
COPD Transitional Care Management Clinic

PROGRAM DETAILS
What to expect during your visit?

Our entire team will be available to assist you with the following issues:

Severity of COPD and appropriate treatment:
- We will review with you use of your inhalers and other COPD medications.

Other medical conditions:
- Our tobacco cessation specialist can assist.

Review your need for oxygen or respiratory assist devices:
- If you are using oxygen or a CPAP or BiPAP machine, we will review your needs and assist with any equipment issues that you may have.

Review your ability to exercise:
- We will review your needs and options for physical activity, including need for pulmonary rehabilitation.

Review your emotional and social needs:
- We want to provide the best support possible for you to achieve your overall wellness goals.

COPD Transitional Care Management Clinic
3rd Floor Taubman Center, Reception C
1500 E. Medical Center Dr.
Ann Arbor, MI 48109-5360
Phone: 1-888-284-5864 8am – 5pm
Fax: 734-936-3484
Clinic Appointments: Friday: 7:30 am – Noon
Physician based value modifier program

- Adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians based on the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries.

- Intended to provide actionable data.

- Reimburses based on value as opposed to volume.

- Physician Quality Reporting Measure (PQRM)
VM: Scoring

- Clinical care (20%)
- Patient experience (20%)
- Patient Safety (20%)
- Care Coordination (20%)
- Efficiency (20%)

Quality of Care Composite Score (50%)

Cost Composite Score (50%)

Note: if no measures exist for a domain, that domain is eliminated and the remaining domains are weighted equally.

Value-based Modifier Amount
Endorsement Summary: Pulmonary and Critical Care Measures

AUGUST 2012

Purpose of the Project

Chronic lung disease – asthma, chronic obstructive pulmonary disease (COPD), and pneumonia – affects some 33 million Americans and is the third leading cause of death in the United States. Asthma alone afflicts an estimated 23 million people, including seven million children who miss 14 million days of school a year because of it. COPD cost the nation $50 billion in 2010, and

What Was Endorsed

Summary of Pulmonary and Critical Care Endorsement Maintenance Measures Project

<table>
<thead>
<tr>
<th>Measure submitted for consideration</th>
<th>Maintenance</th>
<th>New</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>35*</td>
<td>8</td>
<td>43</td>
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<tr>
<td>Measures</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>
### B - Patient Care

- Asthma Action Plan (Adult) - Provider level
- Asthma Action Plan (Pediatrics) - Provider level
- Asthma Controller Medication (Adult) - Provider level
- Asthma Controller Medication (Pediatrics) - Provider level
- Asthma Current Tobacco User (Adult) - Provider level
- Asthma Pneumococcal Vaccine (Adult) - Provider level
- Asthma Tobacco Use Documented (Adult) - Provider level
- Returns to ED within 72 Hours after Discharge - Internal Medicine-Pulmonary PA/NPs
- Unscheduled Readmissions within 30 Days after Discharge - Internal Medicine-Pulmonary PA/NPs

### D - Professionalism

- Flu Shot Compliance
- MLearning - Fire Safety for Clinicians in Patient Care Areas
- MLearning - UMHS Compliance for All Staff
- MLearning - UMHS Critical Incident
- TB Compliance

### E - Interpersonal and Communication

- OCS Patient Relations Reports

### G - Practice Based Learning and Improvement

- Internal CME/Conference Attendance (Internal AMA PRA Category 1 Credits)

### H - Patient Experience

- Patient Experience: Office followed up with test results
- Patient Experience: Provider explained things in a way you understand
- Patient Experience: Provider gave easy to understand info in response to questions/concerns
Do Patients of Subspecialist Physicians Benefit from Written Asthma Action Plans?

Beverley J. Sheares¹, Robert B. Mellins†¹, Emily Dimango², Denise Serebrisky³, Yuan Zhang⁴, Michael R. Bye*¹, Mark E. Dovey†⁵, Sami Nachman⁶, Vincent Hutchinson⁷, and David Evans¹,⁸

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Abstract

Rationale: Asthma clinical guidelines suggest written asthma action plans are essential for improving self-management and outcomes. Quality of life from baseline to 12-month follow-up. Both groups showed similar and significant reductions in asthma symptom frequency (daytime symptoms \( P < 0.0001 \), nocturnal symptoms \( P < 0.0001 \), \( \beta \)-agonist use \( P < 0.0001 \)). There was also a significant reduction in emergency visits for the intervention.
Areas for Review

A. Ambulatory clinic

B. ICU

C. Bronchoscopy

D. Lung transplant

E. MedPulm service
How can the Quality Council help?

• Contact person for PACE