Certificate Training Program Session 17

Welcome! Before We Begin:

Sign-in at the back
Pick up agenda
Sit with your CTP team at your assigned table

Institute for Healthcare Quality, Safety and Efficiency
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

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Institute for Healthcare Quality, Safety and Efficiency
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CALL FOR APPLICATIONS

CERTIFICATE TRAINING PROGRAM (CTP)

Learn | Develop | Lead

A professional development program for inter-professional leadership teams of outpatient clinics, hospital units, or multi-site clinical programs.

- Yearlong course combining classroom sessions, coaching, and completion of a process improvement project
- Focus on leadership, change management, team development, patient safety, quality and process improvement

Application & letters of support due April 14, 2025

CLINICAL EFFECTIVENESS & PATIENT SAFETY (CEPS) GRANT

Seeding Promising Ideas

Providing funding to faculty, staff, and trainees up to $25,000 for initiatives at CHCO or UCH with a focus on:

- Innovative process improvements
- Patient safety outcomes
- Increasing healthcare value
- Implementing evidence-based practices

Letter of Intent due April 14, 2025

Anschutz

Need help building your strongest application? Contact us! IHQSE@cuanschutz.edu

Visit ihqse.org for more information

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KEY
Team Check-in
Inspiration
Background
Process Improvement
Leadership
Quality/Safety
Coaching
EMR

1/28	#12	UCH Sleep	Overcoming Resistance	Feedback to Improve Performance	Mid-year Report Practice Session	EMR Build
2/4		Coaching				
2/11	#13	Report Outs			Leading Change: Removing Barriers	EMR Build
2/18		Coaching				
2/25	#14	Report Outs			Running Effective Meetings	EMR Build
3/4		Coaching				
3/11	#15	Using AI for QI		Leadership Journey: Jena Hausmann	Second Victim	EMR Build
3/18		Coaching				
3/25		Coaching				
4/1	#16	DHA Antimicrobial Stewardship	Data to Understand Impact	Positive Organizational Design	Leading Change: Short-term Wins	Production
4/8	#17	CU Medicine Dermatology	Impact of Quality and Safety on Healthcare Finance	Leading through Complexity	Biases & Leadership	Refinement
4/15		Coaching				
4/22	#18	CHCO Nursery	Strategic Planning		QI Spread	Power & Influence	Refinement
4/29		Coaching				
5/13	#19	UCH Infectious Diseases	Burnout & Resilience	Innovation in Healthcare	Embed the Change	Data Extraction
5/20		Coaching				
5/27	#20	Leadership Journey: Dean Sampson	Report Outs			Data Extraction
6/3		Coaching				
6/10	#21	Report Outs				Data Extraction
6/17		Coaching				
6/24	#22	Reflecting on Why		Certificates	Closing Time	Data Extraction

3

KEY | Team Check-in | Inspiration | Background | Process Improvement | Leadership | Quality/Safety | Coaching

Coaching	**Finalize barrier removal**			
#16 Apr. 1	Team Check-in: DHA Antimicrobial Stewardship	Who are my colleagues?	❑ **Create a series of short-term wins to support project** *Due April 22*	
	Data to Understand Impact	How do I know if my project has made a significant change?		
	Positive Organizational Design	How do I build a high-performing culture?	❑ **Update data plan to include current state data** *Due April 22*	
	Leading Change: Short-term Wins	How do I reward people as a way to build momentum for change?		
#17 Apr. 8	Team Check-in: CU Medicine Dermatology	Who are my colleagues?		
	Impact of Quality and Safety on Healthcare Finance	How does quality and safety impact clinical revenue?		
	Leading Through Complexity	How do we develop goals, tactics and plans to meet long-term strategic needs?		
	Biases & Leadership	How can we best address personal biases in medicine?		
Coaching	**Create series of short-term wins to support project, intervention implementation**			
#18 Apr. 22	Team Check-in: UCH Nursery	Who are my colleagues?	❑ **Develop plan for sharing/spreading your work** *Due June 10*	✓ **Create a series of short-term wins to support project**
	Strategic Planning	How do we develop goals, tactics and plans to meet long-term strategic needs?		
	QI Spread	How do I share/spread my project work and outcomes?		✓ **Update data plan to include current state data**
	Power and Influence	What are the sources of power and influence and when do I use these tools?		

4

Today's Learning Objectives

1. Recognize how quality impacts the financial performance of the organization
2. Understand how healthcare is funded in the U.S.
3. Understand the growing move toward value-based payment
4. Recognize the complex nature of our workforce
5. Develop strategies to deal with complexity
6. Understand how leaders can address implicit bias and incivility

CU Medicine Dermatology: Intervention Plan

- Aim Statement
- Inputs
  - Voice of the customer
  - Affinity diagram/Process Map
  - Pre-mortem
- Proposed Intervention

- Team:
  - Whitney High, MD, JD, MEng
  - Ryan Harding

Impact of Quality & Safety on Healthcare Finance

Jennifer Wiler, MD MBA
Tenured Professor, University of Colorado School of Medicine
Co-Founder, UCHealth CARE Innovation Center

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Objectives

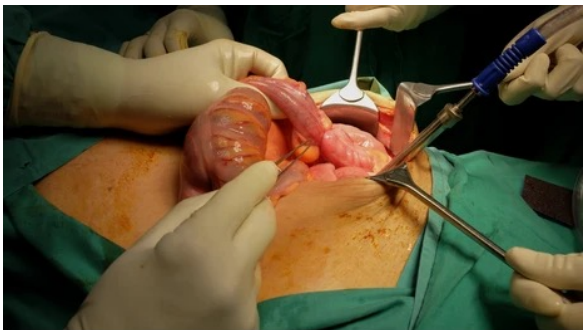
- Recognize how quality impacts the financial performance of healthcare organizations and providers.
- Understand how healthcare is funded in the U.S.
- Understand the (previous?) growing move toward value-based payment.

Case Study

- 69 y. o. female with a past medical history of CHF, asthma, HLD, CKD presents to the OR for sigmoid colectomy in the setting of perforated diverticulitis.
- Index procedure was "*sigmoidectomy primary anastomosis, diverting loop ileostomy, and splenectomy*"
- Attending Op note:

  "…The left lower quadrant was examined and the sigmoid colon was noted to be inflamed and adherent to the lateral abdominal wall. The colon was mobilized along the White line of Toldt. A linear stapler was used to transect the colon proximal to the area of inflammation and at the distal extent of the diseased area."
- Resident OR documentation (outside of the Op Note) states:

  "…Minimal purulent peritonitis…"



Surgical Site Infection Impact

- Increase hospital LOS
  - 8.5-day (non-elective admissions)
  - 7.8-day (elective admissions)
- Increased cost
  - $20,890 (non-elective admissions)
  - $18,410 (elective admissions)
- 1% payment reduction for CMS HAC Program*

PATOS Requirements

PATOS: Present at Time of Surgery	
Documentation needed to capture PATOS	**Alone, does not meet the definition of PATOS**
• Abscess(es) • Purulence/pus/phlegmon • Feculent peritonitis • Ruptured/perforated appendix • Interloop abscess	• Diverticulitis • Peritonitis • Appendicitis • Positive culture or pathology report from surgical specimen • Mention of rupture or perforation of colon • Fecal spillage, enterotomy/nicked bowel during procedure • Note of inflammation, necrosis, or gangrene • Contaminated trauma cases (e.g., fresh gunshot wound to abdomen) • Wound class (e.g., contaminated or dirty)

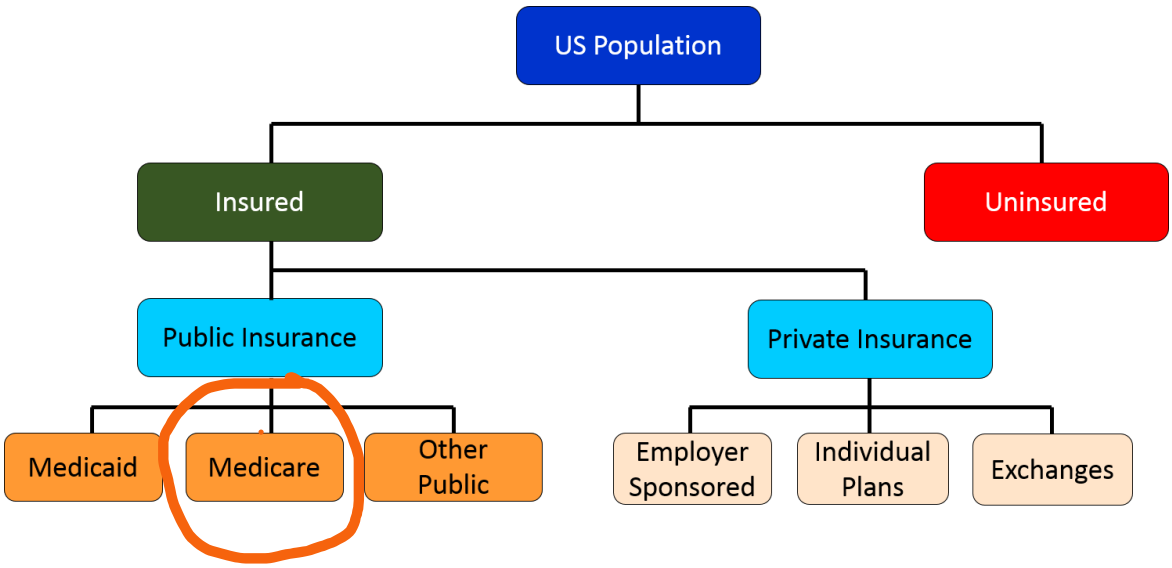
PATOS: Evidence of infection visualized during the surgical procedure to which the SSI is attributed, **AND** Infection must be noted intraoperatively and documented within the narrative portion of the operative note

"The Rules Stink"

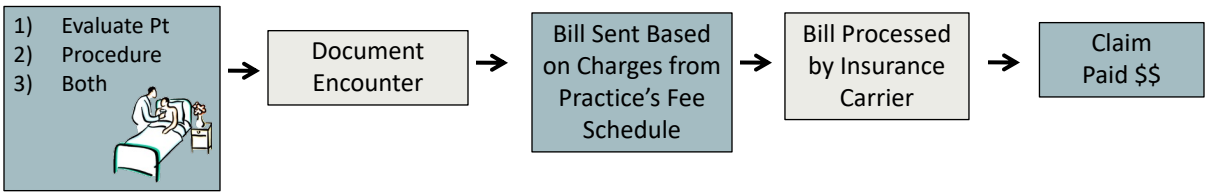
- Tedious
- Confusing
- Don't Let Us Take Care of Patients

Move On…


SANTA CLAUS
1836 - 2000

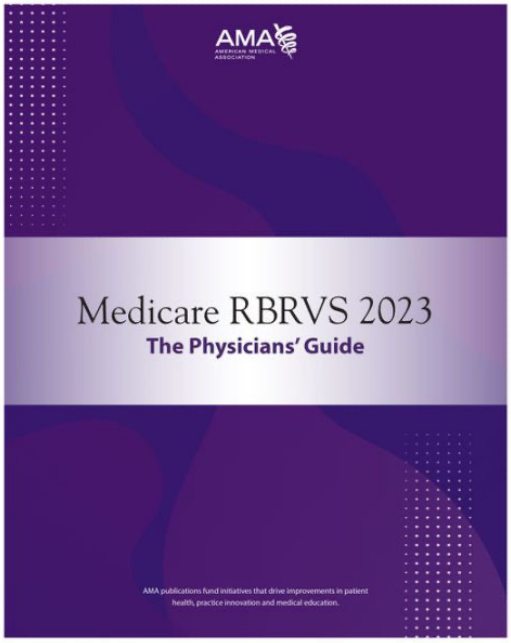

US Population
Insured
Uninsured
Public Insurance
Private Insurance
Medicaid
Medicare
Other Public
Employer Sponsored
Individual Plans
Exchanges
>/= 65 yo

Payment Policy System Pre-1992

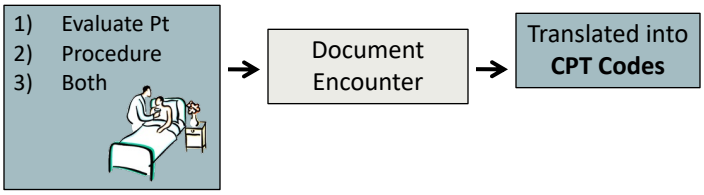


Resource-Based Relative Value Scale (RBRVS)

- 1970's Harvard study initiated
  - Published in 1979, 1984, 1985
- Omnibus Budget Reconciliation Act of 1989
  - Created physician fee schedule
  - Took effect 1992
- Medicare payments
  - Payments for services based on resource costs needed to provide the service



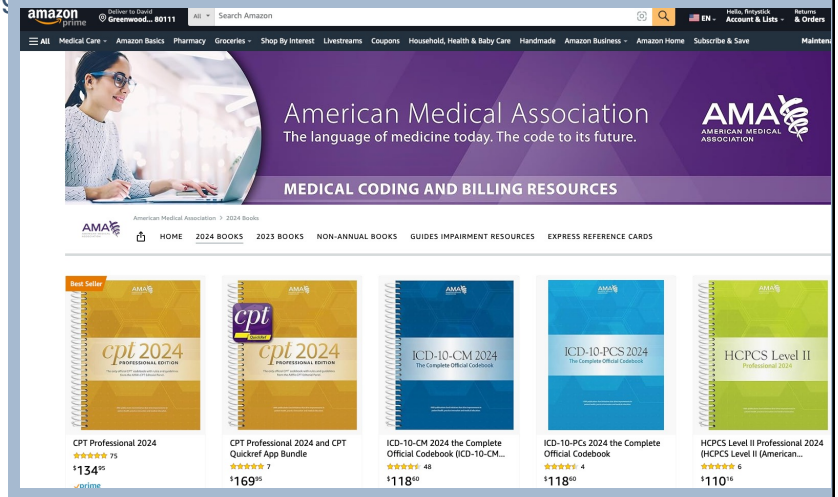
How Do Providers Get Paid Post RBRVS



CPT Codes

Current Procedural Terminolog

- Describe healthcare services provided by “eligible professionals”
  - Clinical providers: physician, APP, DPM, etc)
- Developed by AMA CPT editorial panel
  - Justify medical necessity (ICD-10 dx)
- 2 Types
  - Evaluation & Mgt Codes (“E & M Codes”)
  - Procedure codes



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How Much is a Given CPT Code Worth ($)?

Depends on Resource-Based Relative Value Scale (RBRVS) “Inputs”

RBRVS Inputs

Used to Determine “Resource Cost” of Each Service (CPT Code)

1. Physician Work (wRVU)
   - Cognitive
   - Procedural
2. Practice Expense
   - Supplies, Billing, Collections
   - Support Staff, Payroll
3. Professional Liability Insurance

RBRVS Equation

Work RVUs
+ Practice Expense RVUs
+ Liability Insurance RVUs

Total RVUs for a given CPT code

(RVUTotal) x (Geographic Adjust) x (Conv Factor) = Medicare Payment ($) per CPT Code

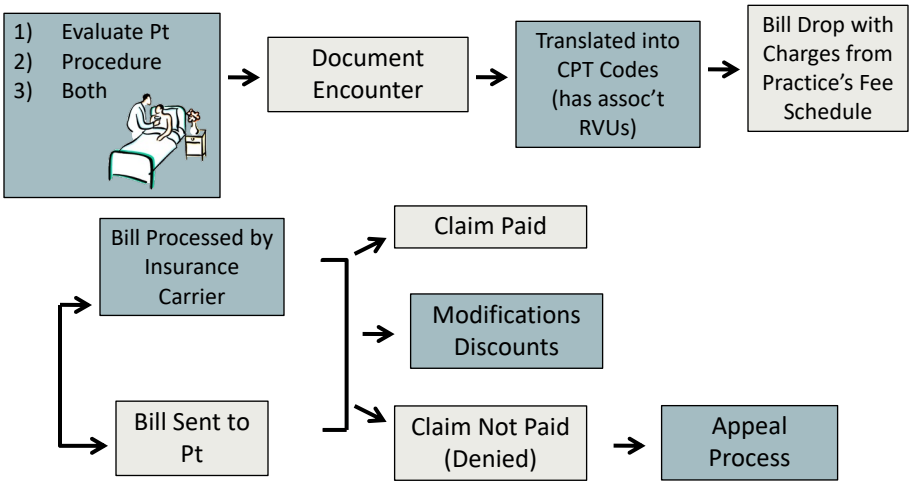
Example: ER Patient in AZ with Abd Pain, Dx as Kidney Stone (CPT Code 99284)

(Work RVUs) x (Work GPCI)
+ (Practice Expense RVUs) x (PE GPCI)
+ (Liability Insurance RVUs) x (PLI GPCI)
= Total RVUs

(2.56)(1.000) + (0.62)(0.983) + (0.22)(0.913)
= 3.37 Total RVUs

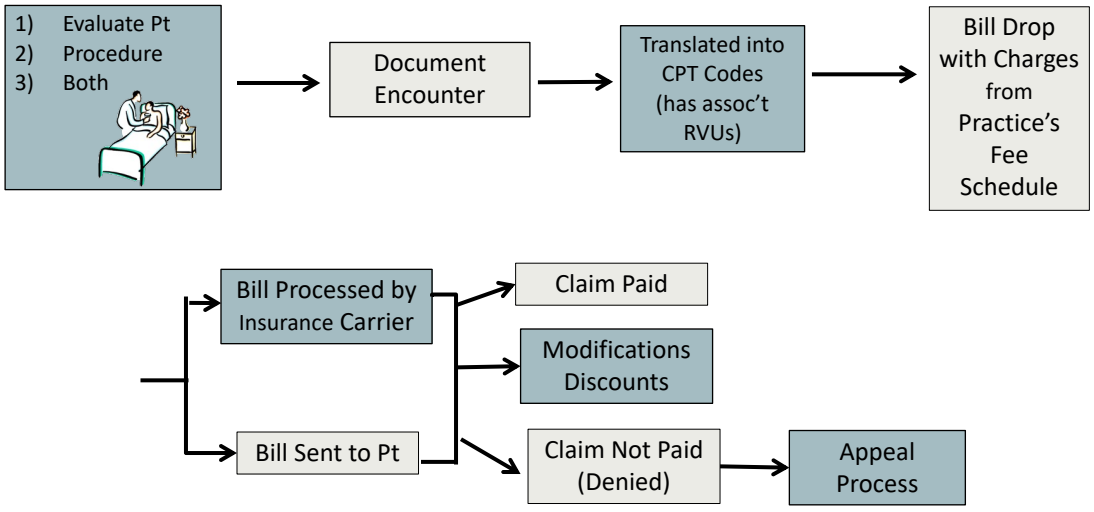
(Total RVUs) x (Conversion Factor) = Medicare Payment $
(3.37) x ($38.8872) = $131.05 Phoenix, AZ

How Do Doctors Get Paid Today

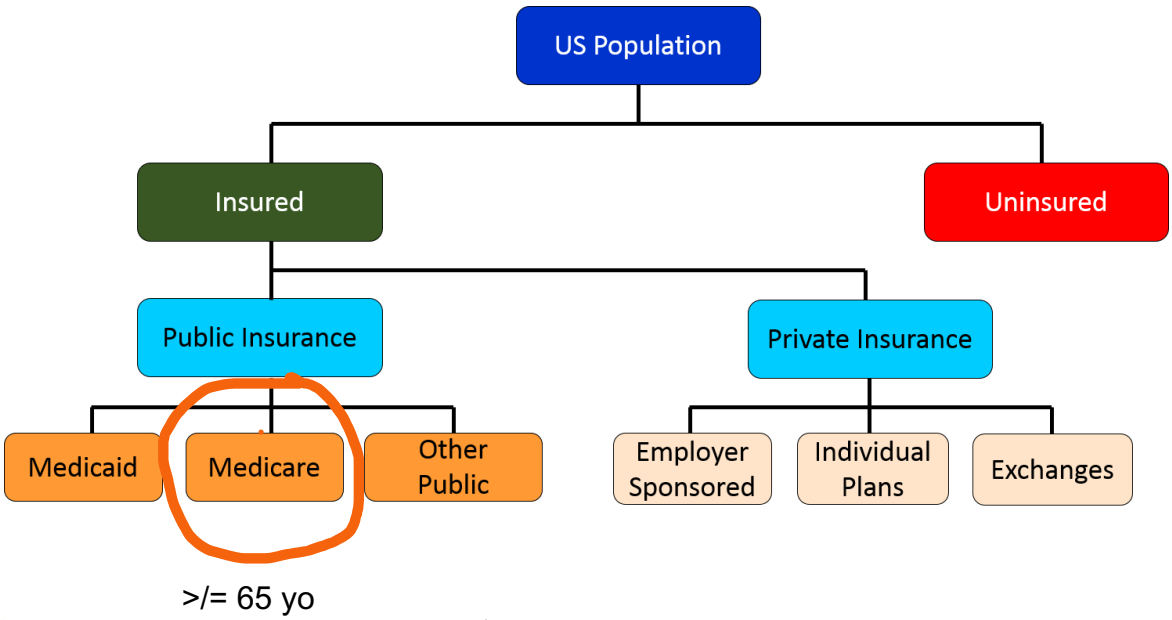


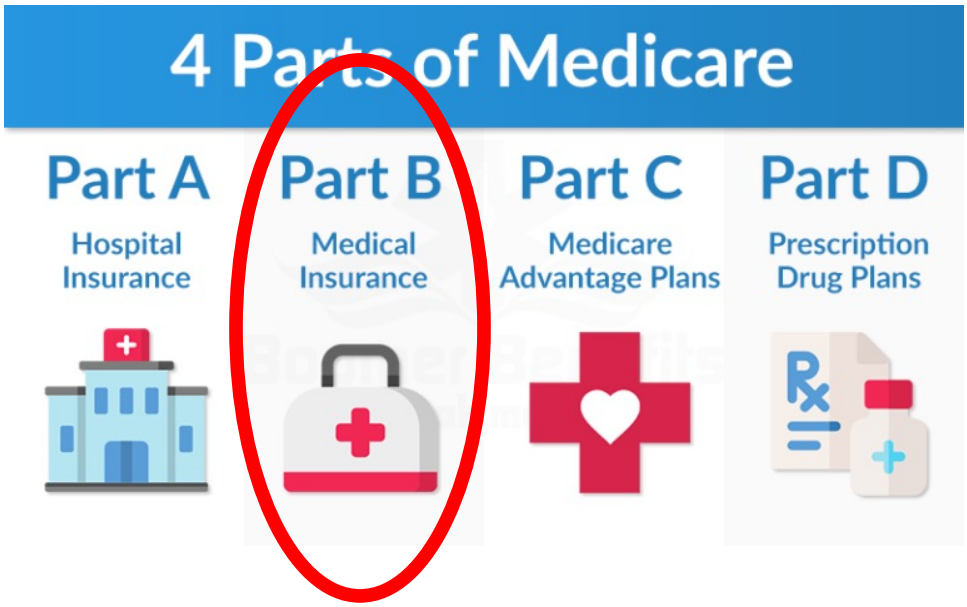
How to Find “Hidden” $

How to Find “Hidden” $’s



“Fee for Service”




4 Parts of Medicare
Part A
Hospital Insurance
Part B
Medical Insurance
Part C
Medicare Advantage Plans
Part D
Prescription Drug Plans

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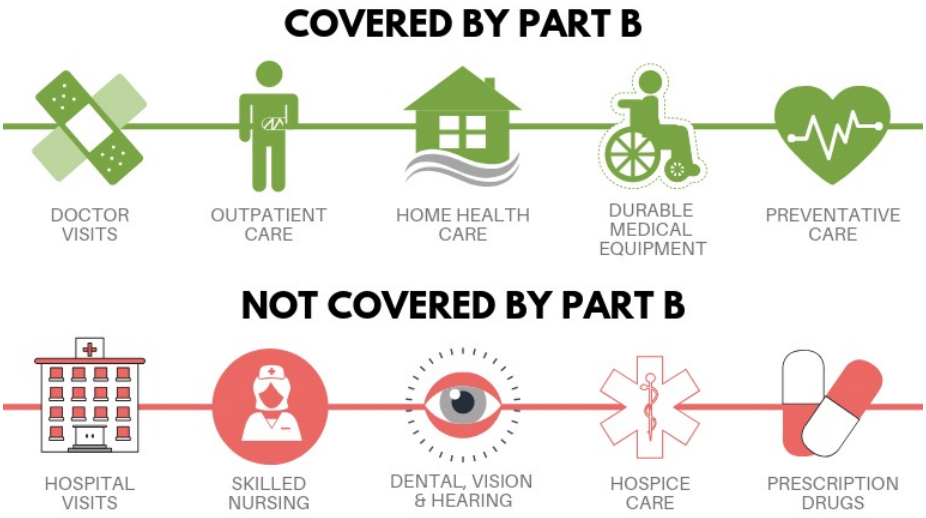
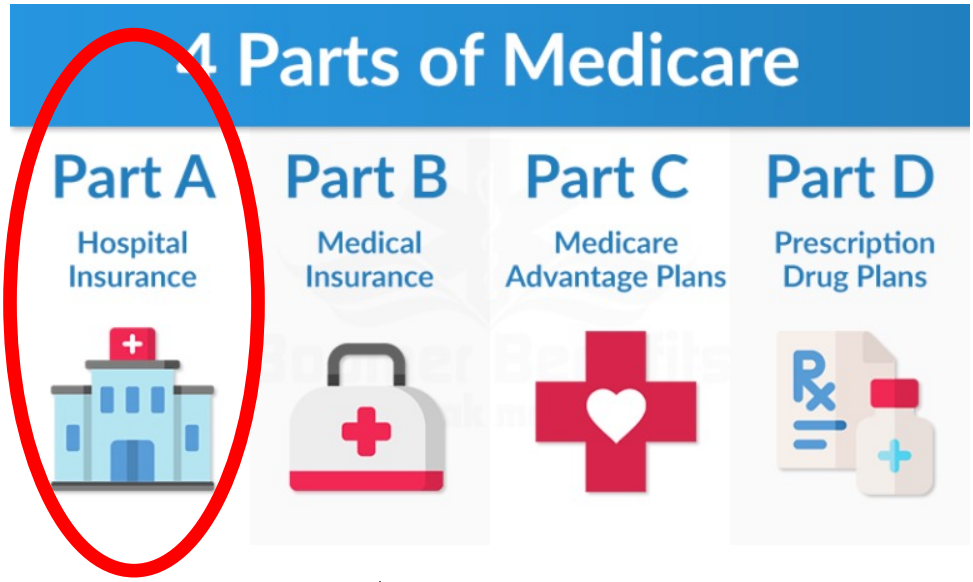

COVERED BY PART B
DOCTOR VISITS
OUTPATIENT CARE
HOME HEALTH CARE
DURABLE MEDICAL EQUIPMENT
PREVENTATIVE CARE
NOT COVERED BY PART B
HOSPITAL VISITS
SKILLED NURSING
DENTAL, VISION & HEARING
HOSPICE CARE
PRESCRIPTION DRUGS

28



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How Are Inpatient Payments Determined?

Role of Case Mix Index (CMI)

CMI = average of relative weights for all DRGs in a facility's population.

Relative weights are assigned to each DRG as an indicator for how many hospital resources were consumed for the treatment of that diagnosis. Resources can include:

- Length of stay
- Surgery/procedures
- Implant costs
- Pharmacy

MS-DRG	CMS GMLOS	Relative Weight
534: Fractures of Femur w/o MCC	2.9	0.7755
165: Major chest procedures w/o CC/MCC	2.9	1.8524
462: Bilateral or Multiple Major Joint Procedures of lower extremity w/o MCC	2.9	3.1941
460: Spinal fusion except cervical w/o CC/MCC	2.9	4.0375

CMS: ICD-10-CM/PCS MS-DRG v37.0 Definitions Manual

Provider documents patient diagnosis and care in Epic throughout patient stay.

Concurrently, **CDI** reviews EHR and queries providers if there is an opportunity to indicate higher severity or conflicting documentation

After discharge, **Coding** assigns ICD-10 codes based on provider documentation

ICD-10 codes are processed through a **grouping software** that assigns a DRG. It considers principal and additional diagnoses, principal and additional procedures, sex, and discharge status.

We submit a bill to the **insurance company** with the DRG; this dictates how we will be reimbursed.

Assuming no denials, we receive **payment** from insurance company.

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Pick Your Code

Service	Description	Code	Payment	Program	Form
"Professional"	Provider "work"	CPT	Medicare Part B		CMS 1500
Ambulatory Care (includes ED)		APC	Medicare A	OPPS	UB 4 form
Inpatient		DRG	Medicare A	IPPS, LTCH PPS	UB 92 form
ASC	Facility		Medicare A	OPPS/ASC	
Ambulance				Ambulance Fee Schedule	
DME, Prosthetics			Medicare Part B		
Pharmaceuticals		HCPCS			

Other Codes - ICD-10 (Diagnosis)

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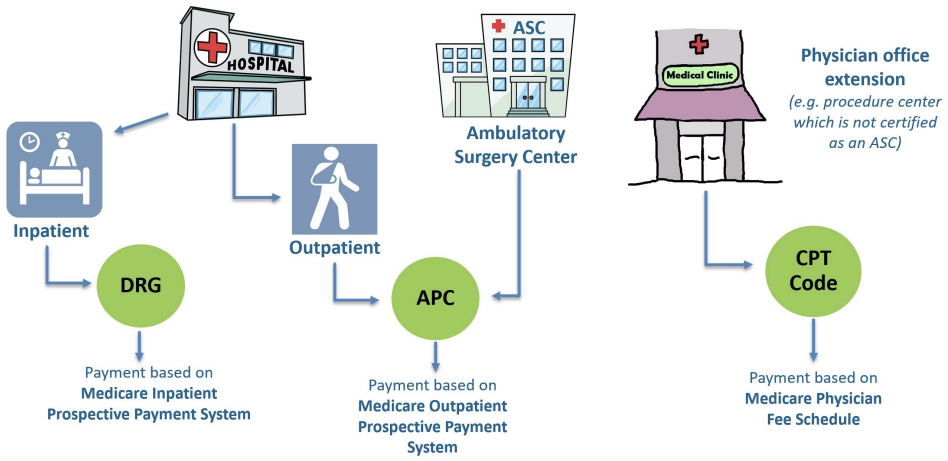

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2000-2010

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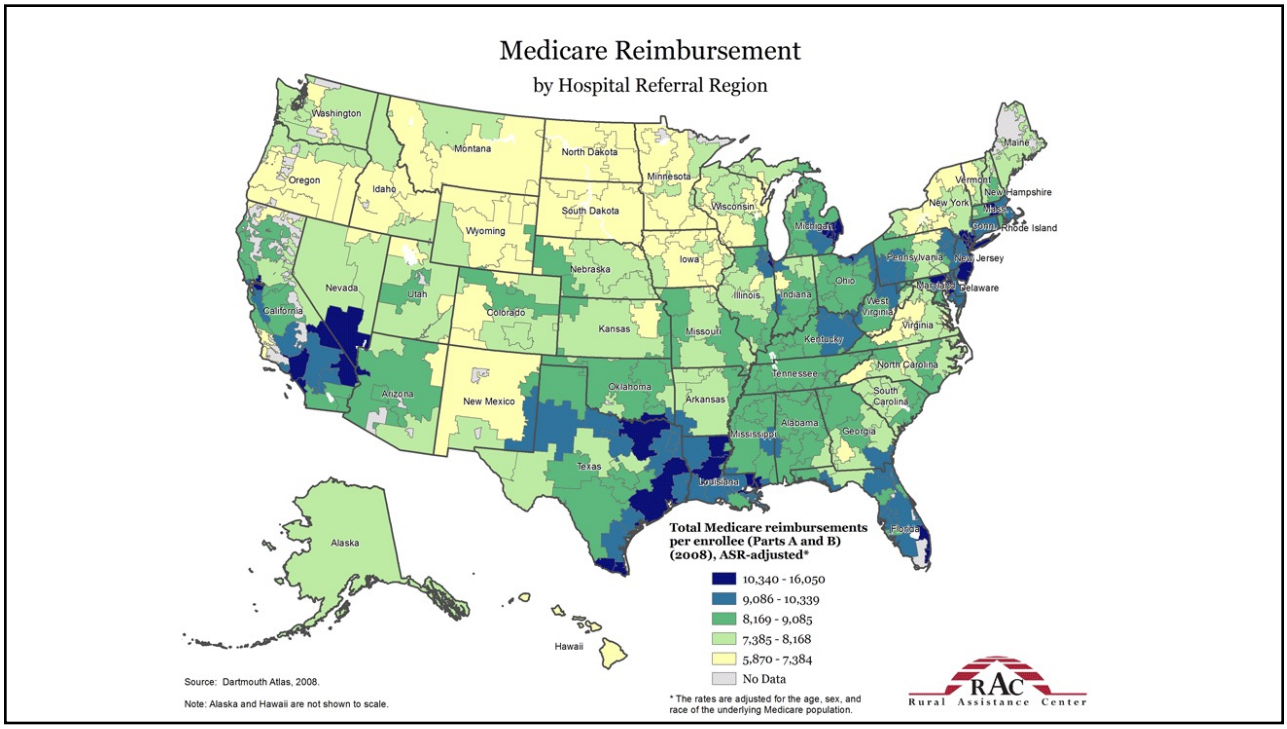
Medicare Reimbursement
by Hospital Referral Region
Washington
Montana
North Dakota
Minnesota
Oregon
Idaho
South Dakota
Wisconsin
Michigan
Wyoming
Nebraska
Iowa
Nevada
Utah
Colorado
Illinois
Indiana
Ohio
California
Kansas
Missouri
West Virginia
Virginia
Kentucky
Tennessee
North Carolina
Arizona
New Mexico
Oklahoma
Arkansas
South Carolina
Mississippi
Alabama
Georgia
Texas
Louisiana
Florida
Alaska
Hawaii
Maine
Vermont
New Hampshire
New York
Massachusetts
Rhode Island
Pennsylvania
New Jersey
Maryland
Delaware
Total Medicare reimbursements per enrollee (Parts A and B) (2008), ASR-adjusted*
10,340 - 16,050
9,086 - 10,339
8,169 - 9,085
7,385 - 8,168
5,870 - 7,384
No Data
* The rates are adjusted for the age, sex, and race of the underlying Medicare population.
Source: Dartmouth Atlas, 2008.
Note: Alaska and Hawaii are not shown to scale.
RAC
Rural Assistance Center

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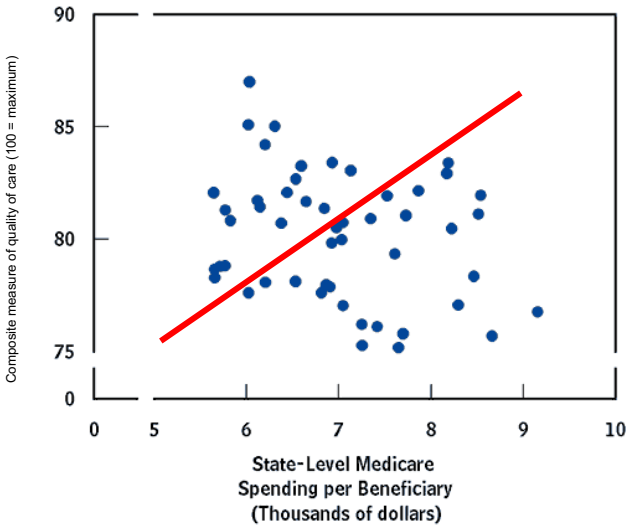
Cost ≠ Quality; Variations by State

Relationship Between Quality of Care and Medicare Spending, by State, 2004



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality

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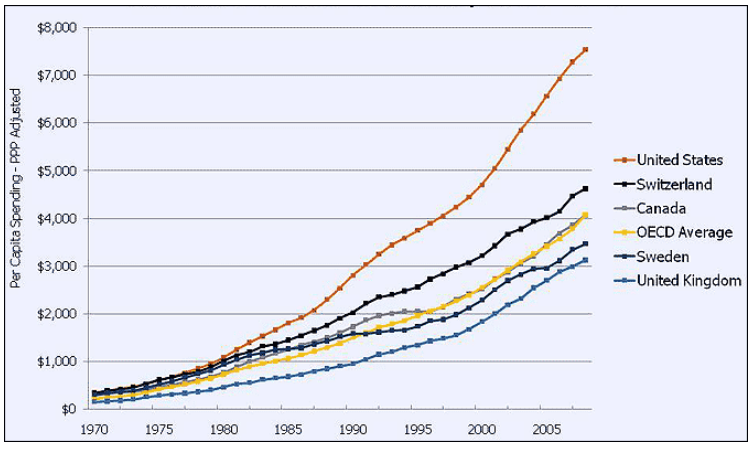
Healthcare Spending "Out of Control"

Growth in Total Health Expenditure Per Capita,
U.S. and Selected Countries, 1970-2008



Kaiser Family Foundation, 2014

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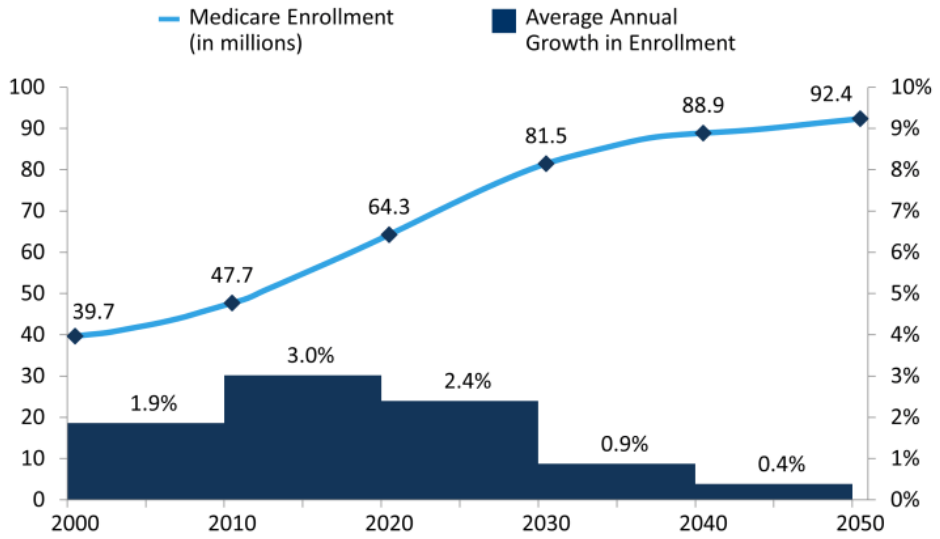
Projected Change in Medicare Enrollment, 2000-2050



SOURCE: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

THE HENRY J. KAISER FAMILY FOUNDATION

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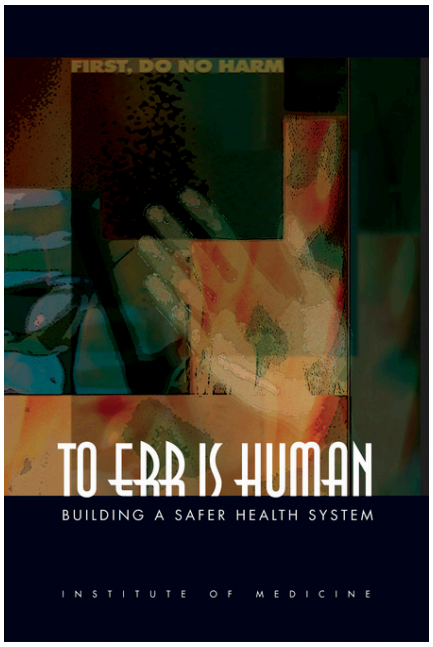

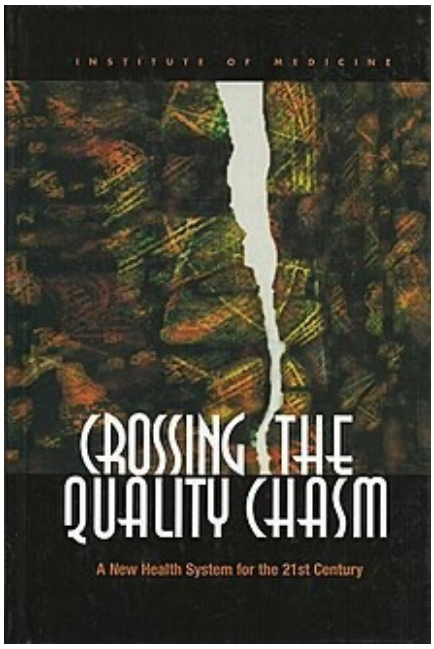

1999 2001

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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act

xt of the Patient Protection and Affordable Care Act (P.L. 111-148)

xt of the Health Care and Education Reconciliation Act (P.L. 111-152)

2010

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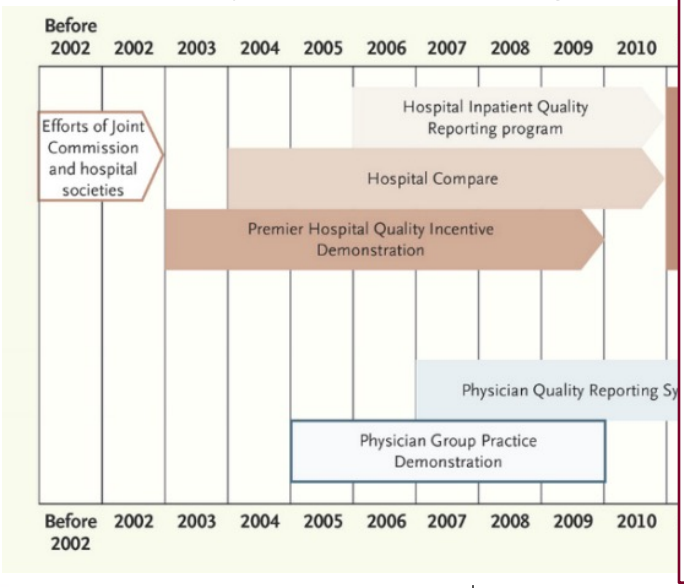
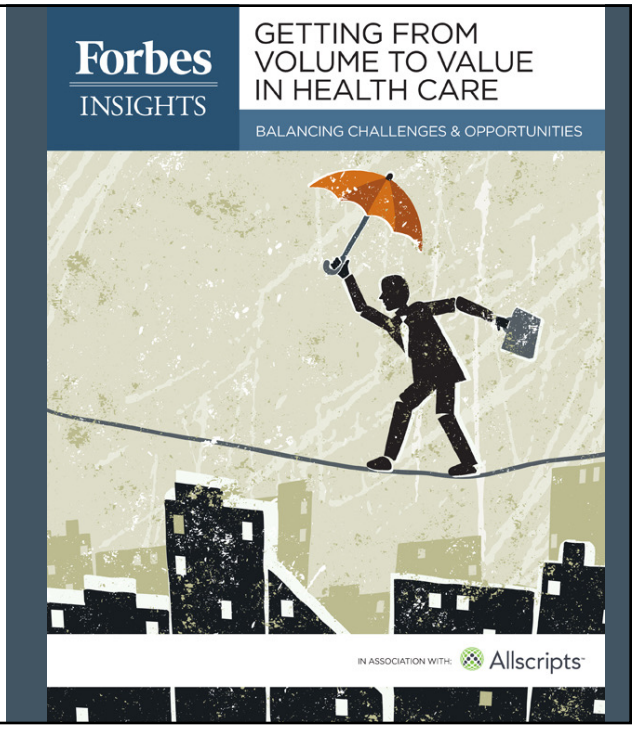
CMS Quality Incentive Programs



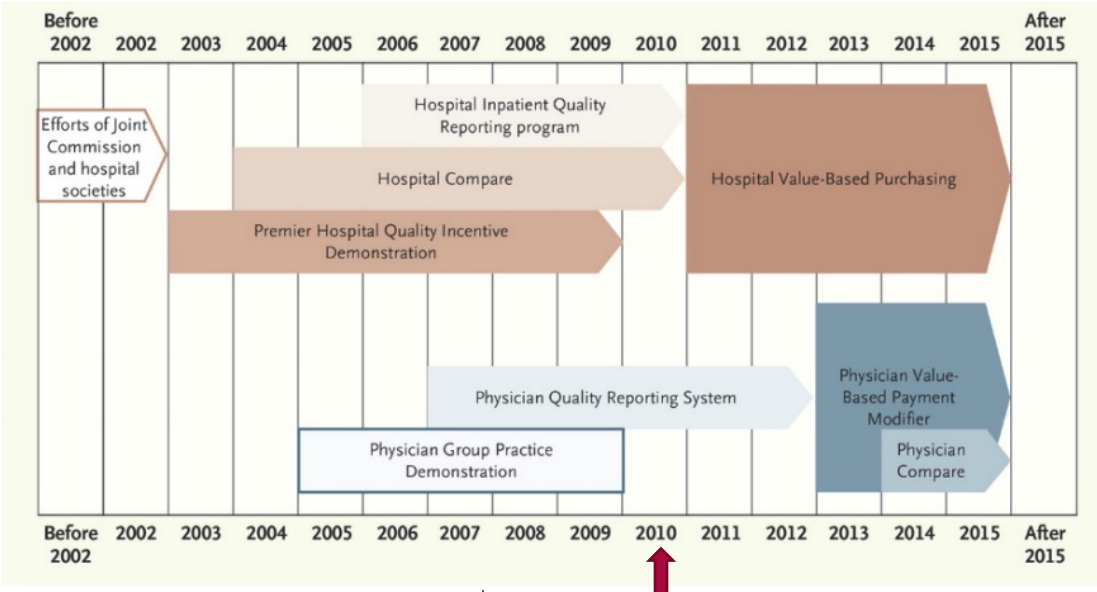
NEJM, 2013

ACA
"Value Based Purchasing" Programs

- Value based modifier
- PQRS (physician quality reporting system)
- Episode payments
- Global payments
- **Accountable Care Organizations (ACO)
- eRx
- Meaningful Use
- Gainsharing



CMS Quality Incentive Programs

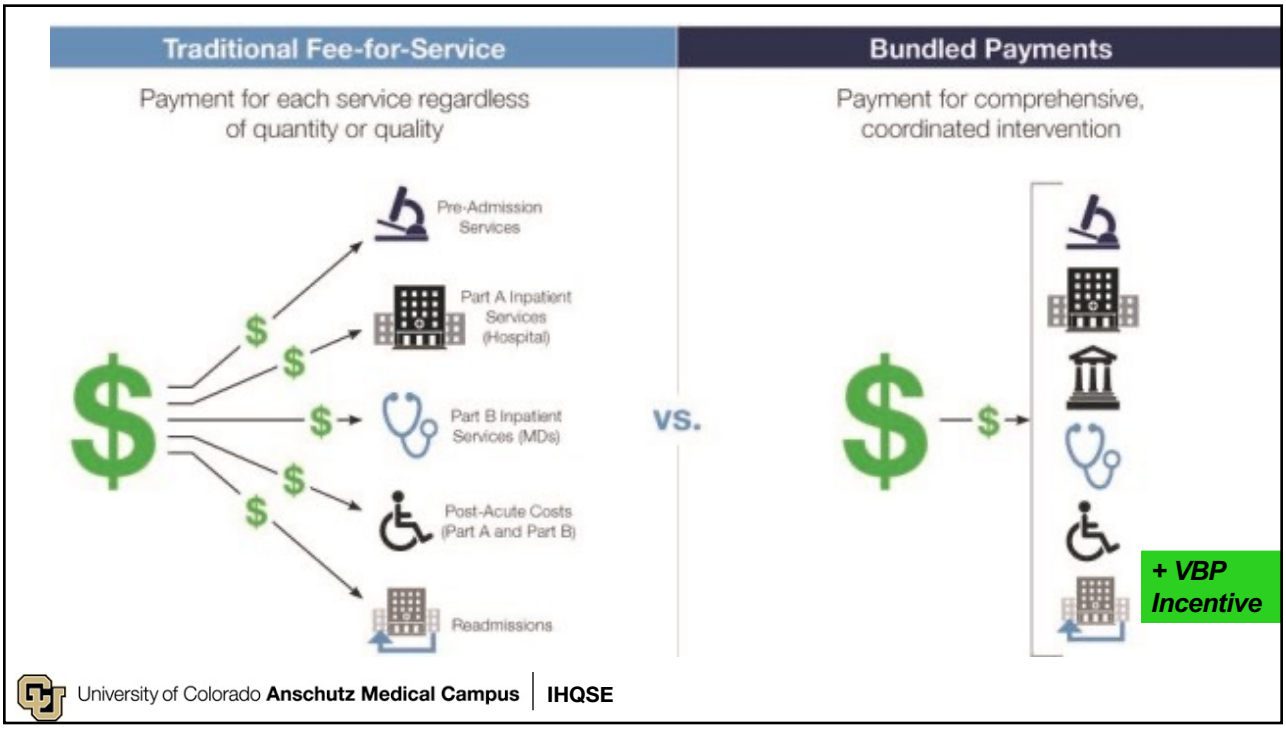


NEJM, 2013

Medicare Strategy


Value as seen by customer
=
Product Quality
i.e. A Flawlessly made product
Price paid by customer

45


Traditional Fee-for-Service
Payment for each service regardless of quantity or quality
Pre-Admission Services
Part A Inpatient Services (Hospital)
Part B Inpatient Services (MDs)
Post-Acute Costs (Part A and Part B)
Readmissions
VS.
Bundled Payments
Payment for comprehensive, coordinated intervention
+ VBP Incentive
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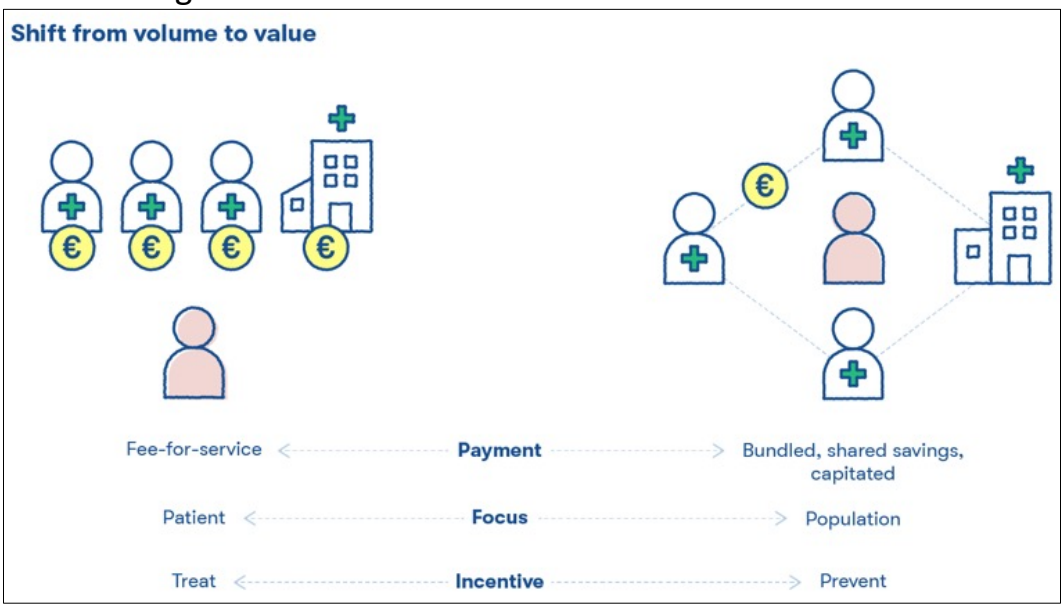
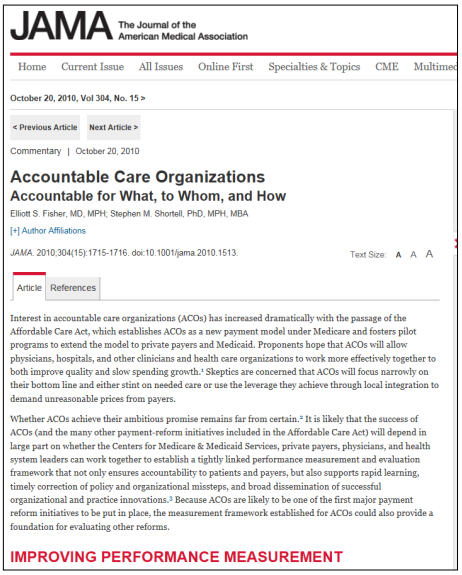
Value Based Programs



Manager of "Alternative" Payment



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October 20, 2010, Vol 304, No. 15 >

< Previous Article Next Article >

Commentary | October 20, 2010

Accountable Care Organizations

Accountable for What, to Whom, and How

Elliott S. Fisher, MD, MPH; Stephen M. Shortell, PhD, MPH, MBA

[+] Author Affiliations

JAMA. 2010;304(15):1715-1716. doi:10.1001/jama.2010.1513.

Text Size: A A A

Article References

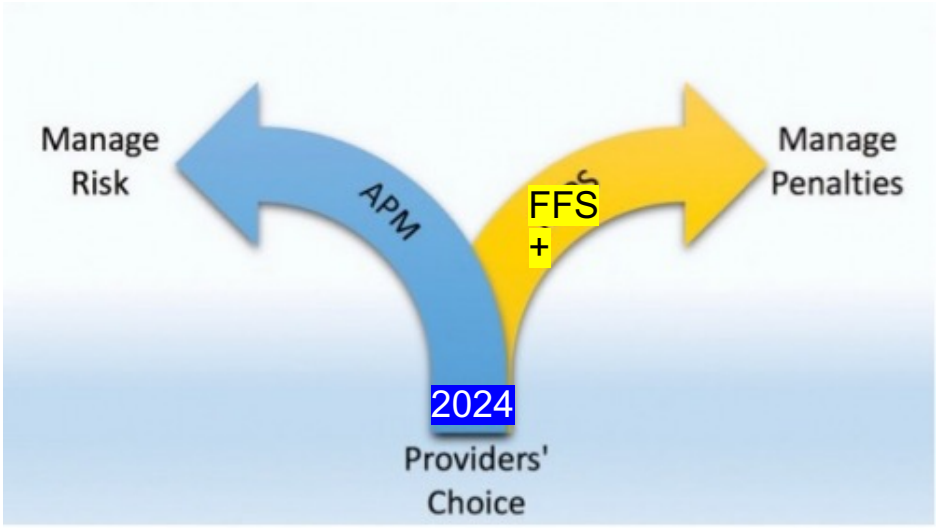
Interest in accountable care organizations (ACOs) has increased dramatically with the passage of the Affordable Care Act, which establishes ACOs as a new payment model under Medicare and fosters pilot programs to extend the model to private payers and Medicaid. Proponents hope that ACOs will allow physicians, hospitals, and other clinicians and health care organizations to work more effectively together to both improve quality and slow spending growth.[1] Skeptics are concerned that ACOs will focus narrowly on their bottom line and either stint on needed care or use the leverage they achieve through local integration to demand unreasonable prices from payers.

Whether ACOs achieve their ambitious promise remains far from certain.[2] It is likely that the success of ACOs (and the many other payment-reform initiatives included in the Affordable Care Act) will depend in large part on whether the Centers for Medicare & Medicaid Services, private payers, physicians, and health system leaders can work together to establish a tightly linked performance measurement and evaluation framework that not only ensures accountability to patients and payers, but also supports rapid learning, timely correction of policy and organizational missteps, and broad dissemination of successful organizational and practice innovations.[3] Because ACOs are likely to be one of the first major payment reform initiatives to be put in place, the measurement framework established for ACOs could also provide a foundation for evaluating other reforms.

IMPROVING PERFORMANCE MEASUREMENT

Who Can Form ACO?

- Group practices
- Integrated delivery systems (e.g. Geisinger)
- Networks of individual practices. (e.g. IPA)
- Partnerships or joint venture arrangements between hospitals and other providers (e.g. PHO)
- Hospitals employing other providers
- Regional Collaborations of health providers (NC Community Connections 646 Project)



CMS.gov | Centers for Medicare & Medicaid Services

Blog RSS Feed Arc

Nov 07, 2022

The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care

By: Liz Fowler, JD, PhD, Purva Rawal, PhD, Sarah Fogler, PhD; Brian Waldersen, MD, MPH;, Meghan O'Connell, MPH; Jacob Quinton, MD, MSHS

Innovation models | Medicaid & CHIP | Medicare Parts A & B

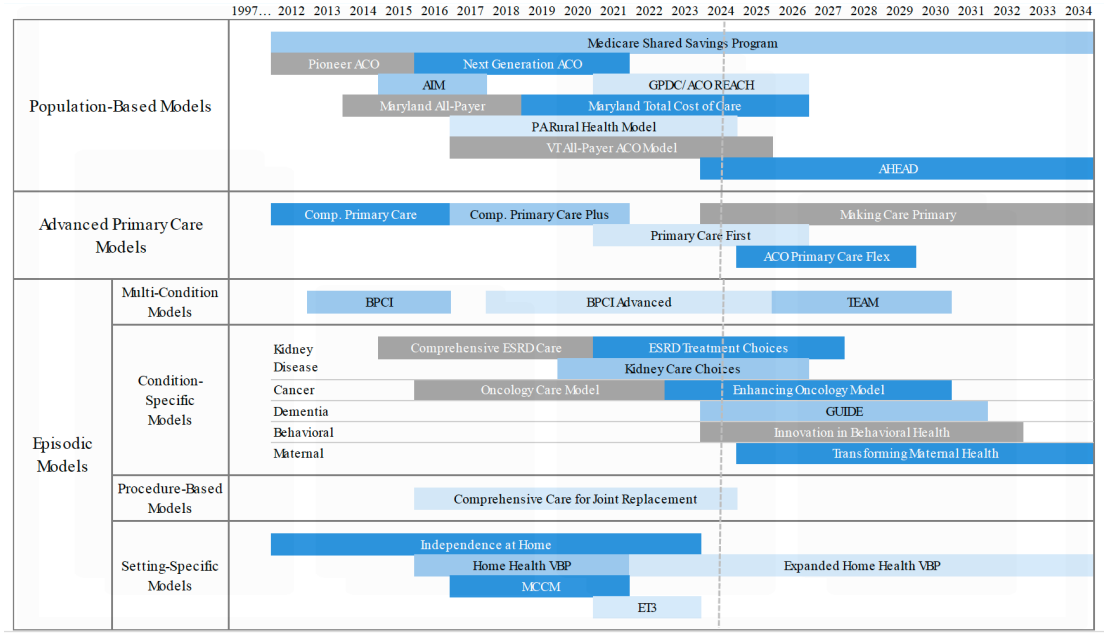
Share

Background

In 2021, the Centers for Medicare & Medicaid Services (CMS) established a goal to have 100 percent of Original Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030 as part of the Center for Medicare and Medicaid Innovation's (Innovation Center) strategic refresh. This means that beneficiaries should experience longitudinal, accountable care with providers that are responsible for the quality and total cost of their care. Accountable care requires access to and coordination of primary care and specialty care to meet

51

CMS & CMMI Value-Based Care Programs

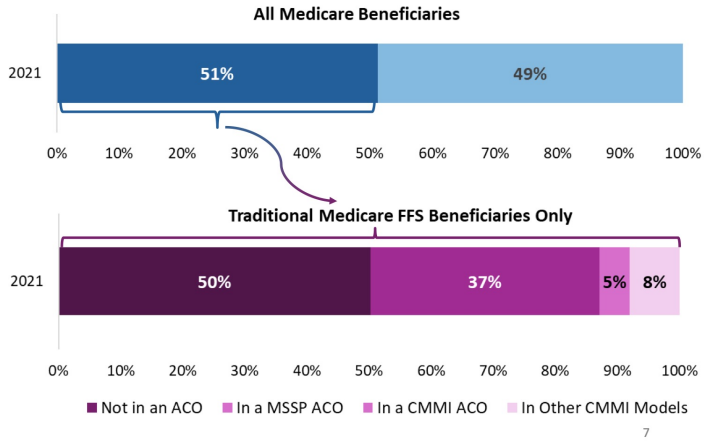


52

Current State

Medicare Beneficiaries in Alternative Payment Models (APMs), 2021

- As of 2021, half of Medicare beneficiaries (51%) were in traditional Medicare (FFS)
- Half of Medicare FFS beneficiaries (50%) were in APMs in 2021



* Note: This analysis includes 21 Advanced Payment Models (excluding Bundled Payments for Care Improvements Initiative (BPCI) and Comprehensive Care for Joint Replacement (CJR) Models)

Based on Analysis by ASPE and Acumen LLC in support of PTAC

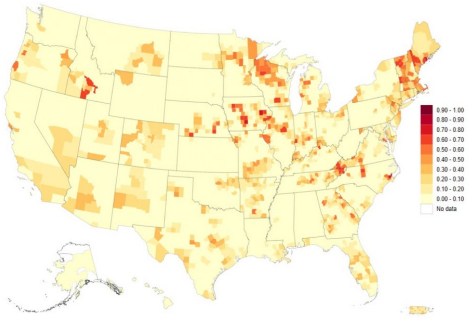
7

Source: ASPE.go

53

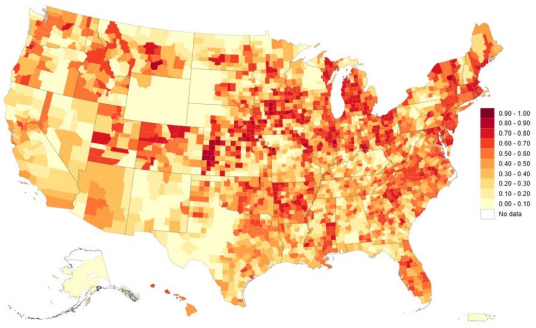
Significant Growth and Variation in APM Penetration Among Medicare Beneficiaries Across the United States, 2013-2022

CMMI or MSSP Penetration by County, 2013



Average APM penetration rate in 2013 was 15%. Significant variation across counties (p10=0.5%, p50=11%, p90=35%).

CMMI or MSSP Penetration by County, 2022



Average APM penetration rate in 2022 was 49%. Significant variation across counties (p10=20%, p50=51%, p90=70%)

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

230%

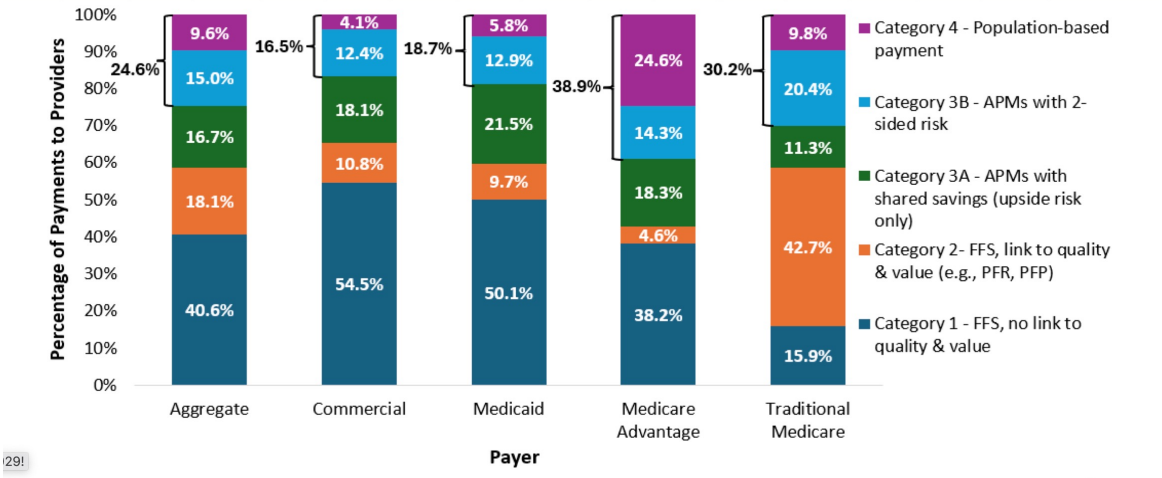
Based on Analysis by ASPE and Acumen LLC in support of PTAC

19

Source: ASPE.gov

54

Percentage of Payments to Providers by Alternative Payment Model (APM) Payment Category* and Payer Type, 2022



(29!

9

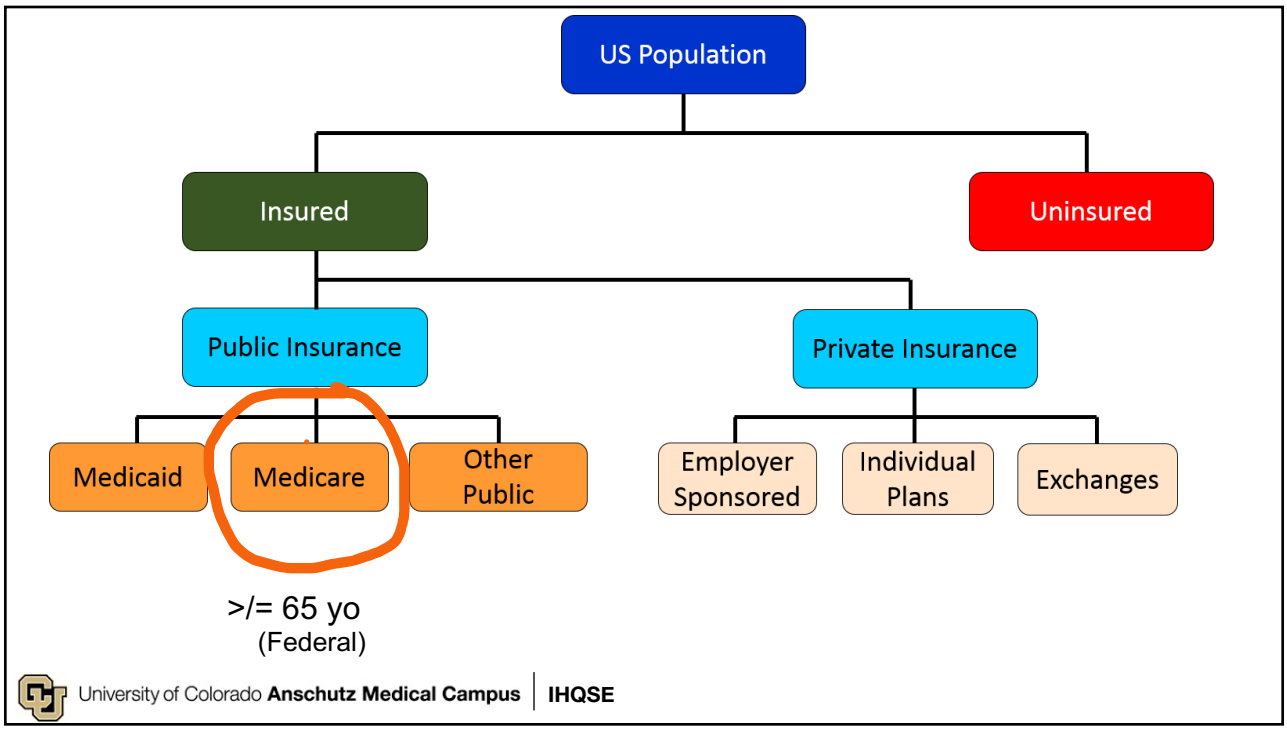
* Payment categories and data are from the Health Care Payment Learning & Action Network (HCP-LAN)

University of Colorado **Anschutz Medical Campus** | **IHQSE**

Reference: ASPE.gov

55

56


US Population
Insured
Uninsured
Public Insurance
Private Insurance
Medicaid
Medicare
Other Public
Employer Sponsored
Individual Plans
Exchanges
>/= 65 yo
(Federal)
University of Colorado Anschutz Medical Campus | IHQSE

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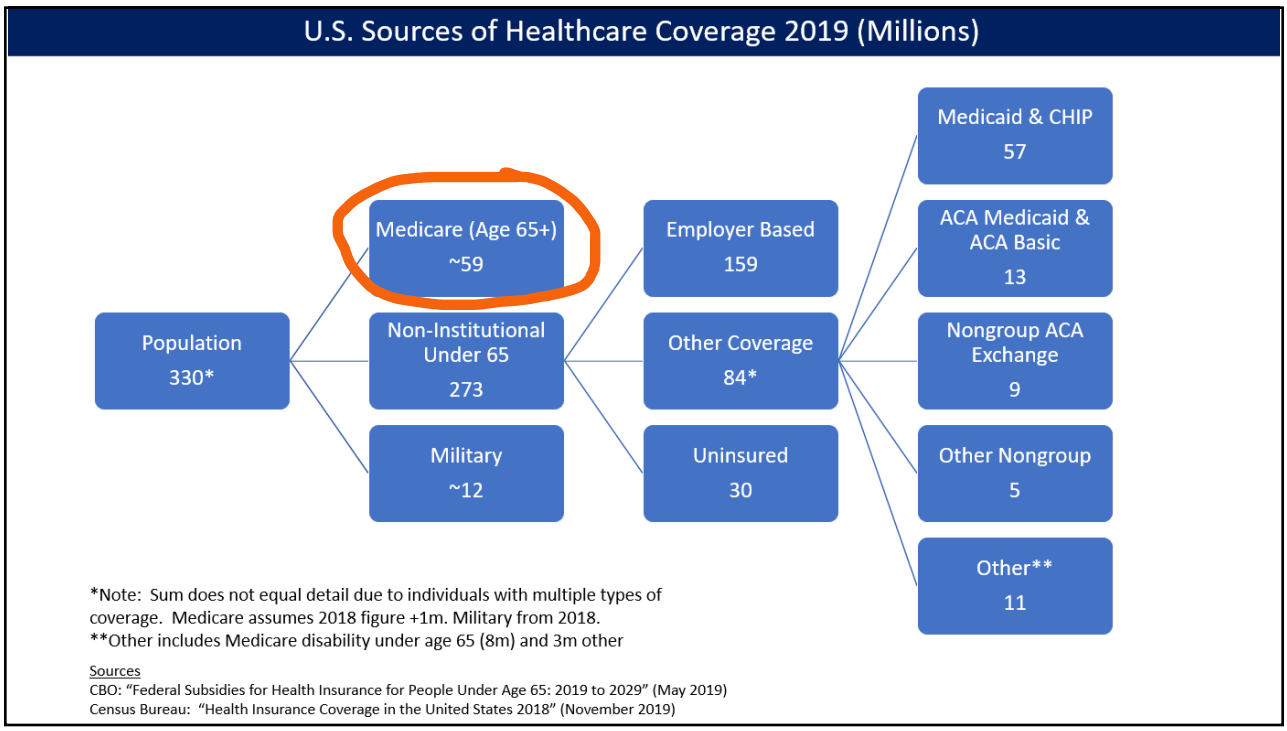
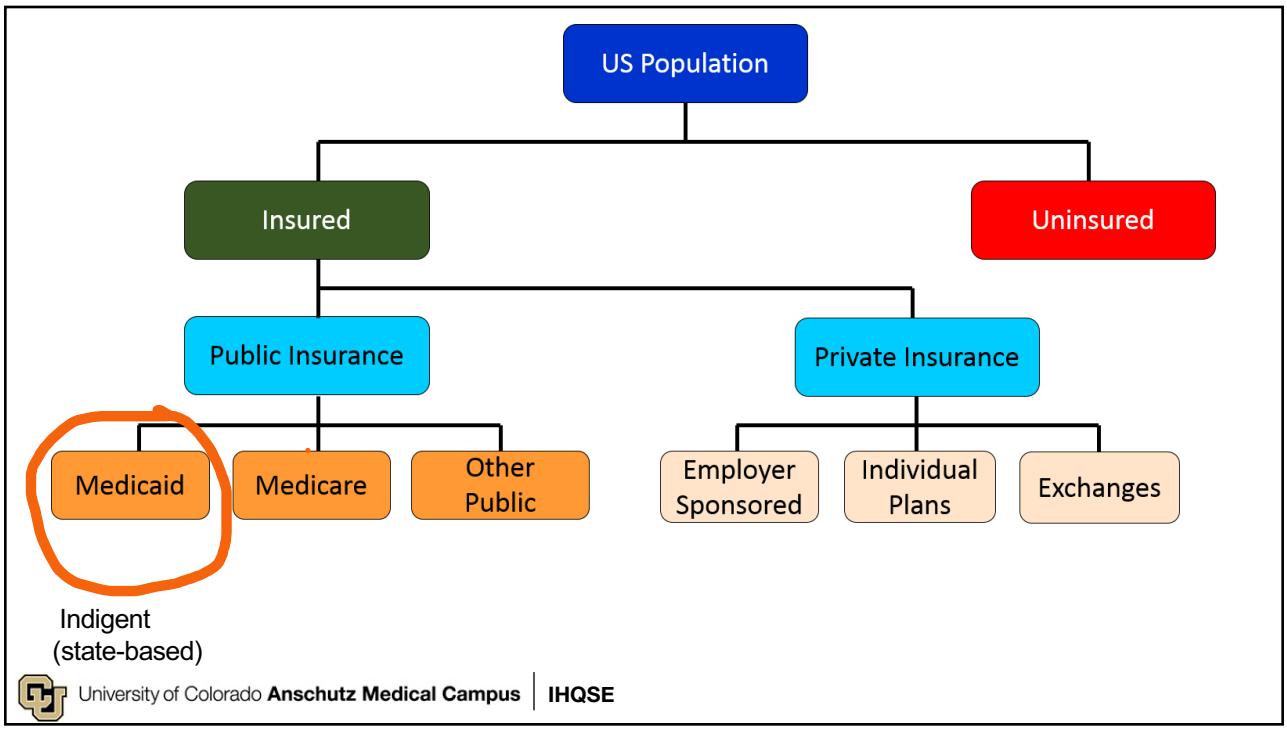

U.S. Sources of Healthcare Coverage 2019 (Millions)
Population
330*
Medicare (Age 65+)
~59
Non-Institutional Under 65
273
Military
~12
Employer Based
159
Other Coverage
84*
Uninsured
30
Medicaid & CHIP
57
ACA Medicaid & ACA Basic
13
Nongroup ACA Exchange
9
Other Nongroup
5
Other**
11
*Note: Sum does not equal detail due to individuals with multiple types of coverage. Medicare assumes 2018 figure +1m. Military from 2018.
**Other includes Medicare disability under age 65 (8m) and 3m other
Sources
CBO: "Federal Subsidies for Health Insurance for People Under Age 65: 2019 to 2029" (May 2019)
Census Bureau: "Health Insurance Coverage in the United States 2018" (November 2019)

58


US Population
Insured
Uninsured
Public Insurance
Private Insurance
Medicaid
Medicare
Other Public
Employer Sponsored
Individual Plans
Exchanges
Indigent (state-based)
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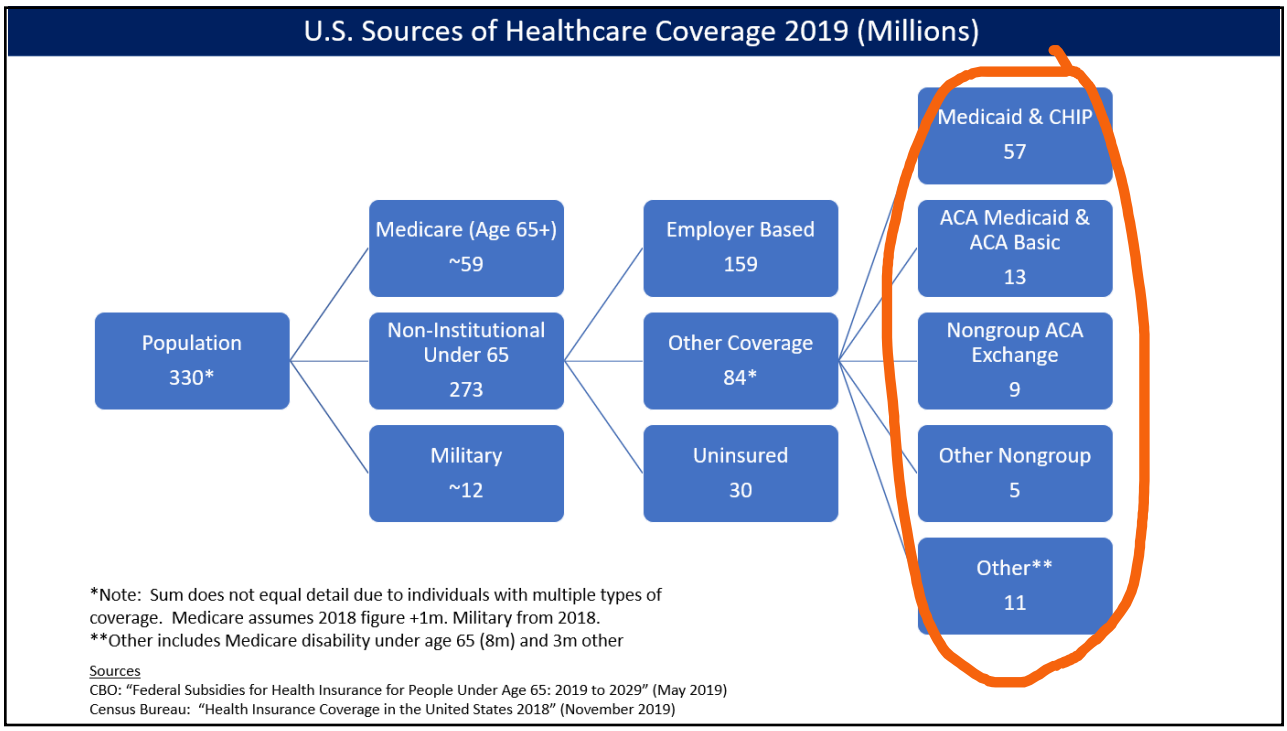
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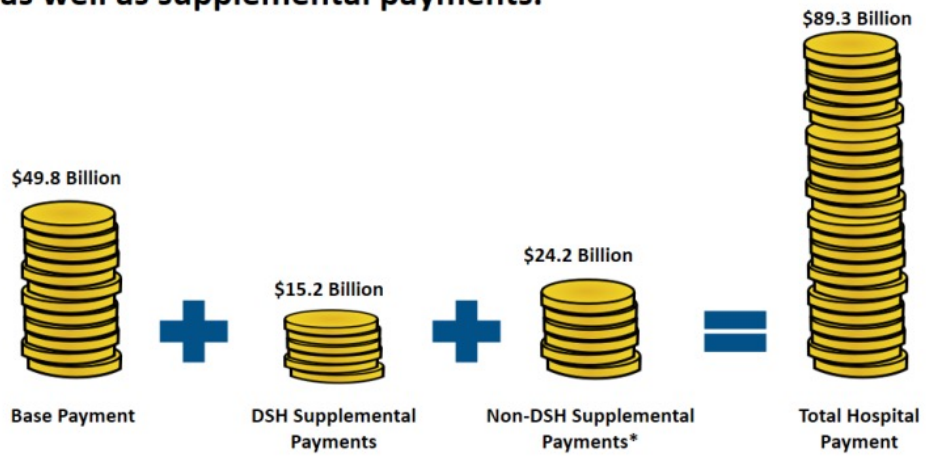
Population 330*
Medicare (Age 65+) ~59
Non-Institutional Under 65 273
Military ~12
Employer Based 159
Other Coverage 84*
Uninsured 30
Medicaid & CHIP 57
ACA Medicaid & ACA Basic 13
Nongroup ACA Exchange 9
Other Nongroup 5
Other** 11
*Note: Sum does not equal detail due to individuals with multiple types of coverage. Medicare assumes 2018 figure +1m. Military from 2018.
**Other includes Medicare disability under age 65 (8m) and 3m other
Sources
CBO: "Federal Subsidies for Health Insurance for People Under Age 65: 2019 to 2029" (May 2019)
Census Bureau: "Health Insurance Coverage in the United States 2018" (November 2019)

60

Medicaid payment to hospitals consists of base payments as well as supplemental payments.



*Includes UPL, IGT, provider taxes and 1115 Waiver payments.
Note: Based on fee-for-service payments only. Data is for 2014.
Source: Medicaid and CHIP Payment and Access Commission. MACStats, Section 3, Exhibit 2. Medicaid Supplemental Payments to Hospital Providers by State, FY 2014, https://www.macpac.gov/publication/medicaid-supplemental-payments-to-hospital-providers-by-state/.

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On Capitol Hill. Haiyun Jiang for The New York Times

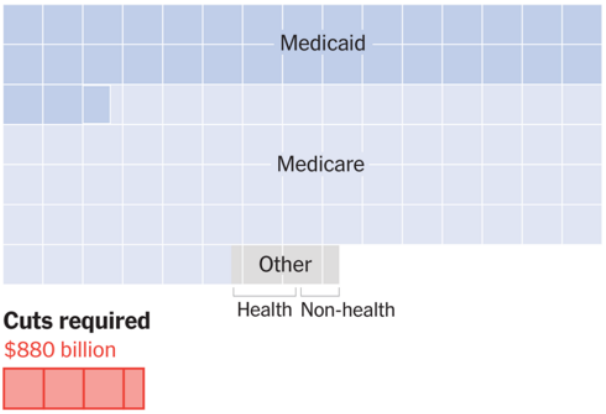
Cutting Medicaid?

By Margot Sanger-Katz
I cover health care.

Republican leaders in Congress have directed the committee that oversees Medicaid to cut $880 billion from the next budget. They say these cuts aren't necessarily *aimed* at Medicaid, the insurance program for 72 million poor and disabled Americans. The cuts could come from Medicare, for instance. But Trump has vowed not to touch that very popular program. And a sum this large can't come from anywhere else.

Spending overseen by the House Committee on Energy and Commerce

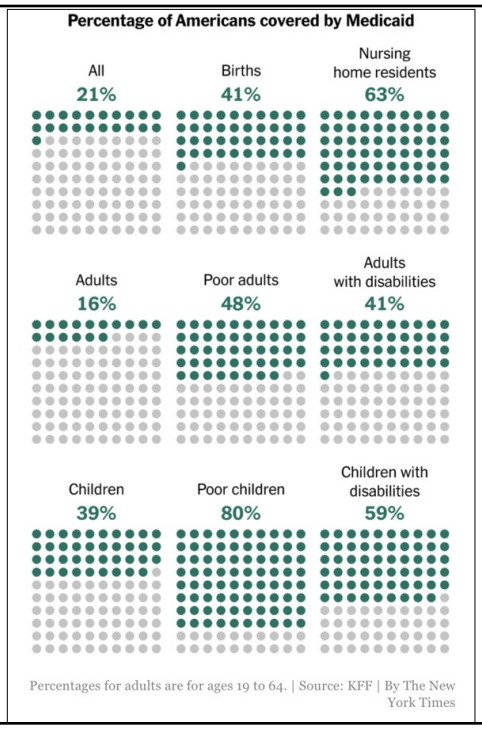
$25 trillion



Cuts required
$880 billion

Each square represents $250 billion in 10-year gross mandatory spending. | Source: Analysis of federal budget data by Richard Kogan, Center on Budget and Policy Priorities | By The New York Times

62



- More than half of Americans say someone in their family has used Medicaid.[1]
- Medicaid and the Children's Health Insurance Program, providing care to nearly 50% of the children in the US.[2]
- Only 17% of American support cutting Medicaid. [1]

1. NYTimes Sanger, March 2025
2. Centers for Medicare and Medicaid Services. Ensuring eligible children maintain Medicaid and Children's Health Insurance Program coverage [Internet]. Baltimore (MD): CMS; 2023 Dec 18 [cited 2025 Jan 14]. (CMCS Informational Bulletin). Available from: https://www .medicaid.gov/federal-policy-guidance/downloads/cib12182023 .pdf

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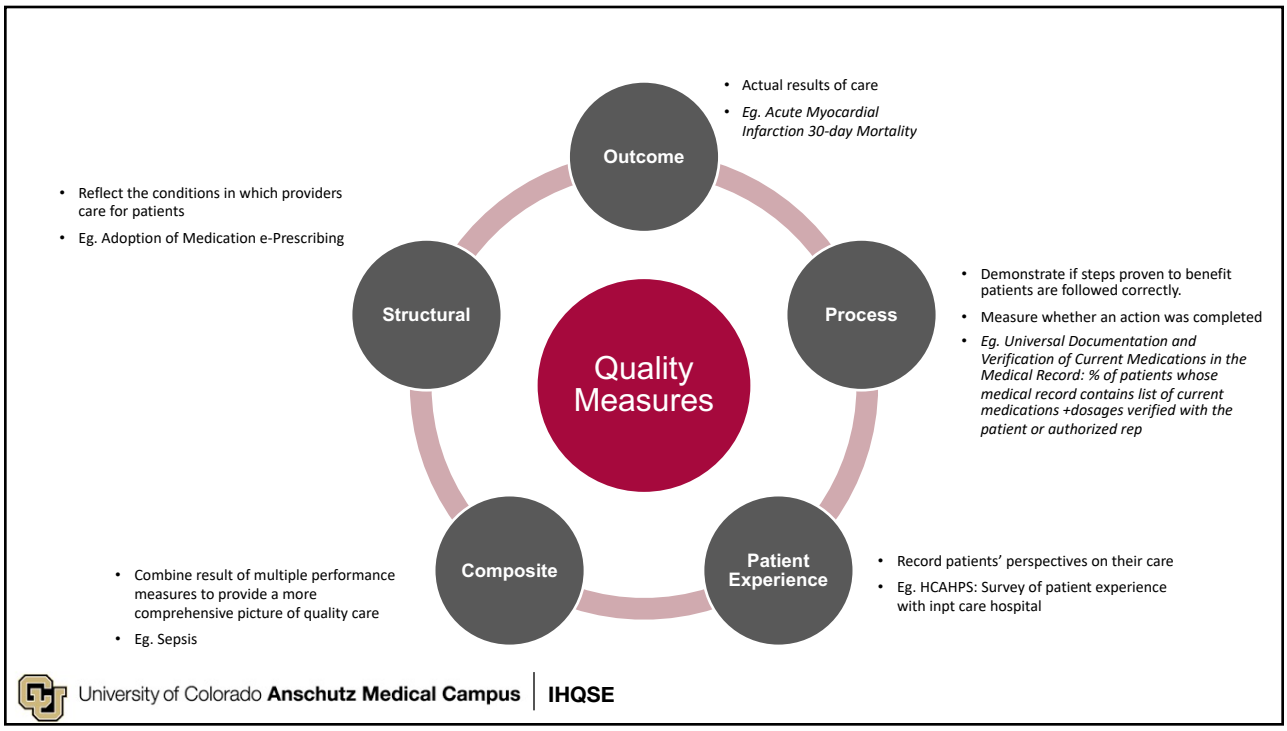
64


Outcome
• Actual results of care
• Eg. Acute Myocardial Infarction 30-day Mortality
Process
• Demonstrate if steps proven to benefit patients are followed correctly.
• Measure whether an action was completed
• Eg. Universal Documentation and Verification of Current Medications in the Medical Record: % of patients whose medical record contains list of current medications +dosages verified with the patient or authorized rep
Patient Experience
• Record patients' perspectives on their care
• Eg. HCAHPS: Survey of patient experience with inpt care hospital
Composite
• Combine result of multiple performance measures to provide a more comprehensive picture of quality care
• Eg. Sepsis
Structural
• Reflect the conditions in which providers care for patients
• Eg. Adoption of Medication e-Prescribing
Quality Measures
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65


?

66

Measure Developers

1. Government & Private Non-Profit

U.S. Department of Health & Human Services

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

The Joint Commission

CMS.gov
Centers for Medicare & Medicaid Services

AMA-convened
PCPI™ Physician Consortium for Performance Improvement®

NCQA
Measuring quality. Improving health care.

American Board of Medical Specialties
Higher standards. Better care®

2. Insurance Carriers

BlueCross BlueShield

TRICARE

CIGNA

UnitedHealthcare®
A UnitedHealth Group Company

3. Academic Institutions

Yale University
LUX ET VERITAS

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Measure Developers

4. Medical Specialty Societies

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

The Society of Thoracic Surgeons

American College of Cardiology Foundation

AGA

College of American Pathologists cap

5. Contractors / Consultants (For Profit)

The LEWIN GROUP®

OPTUMInsight™

Booz | Allen | Hamilton

MATHEMATICA Policy Research

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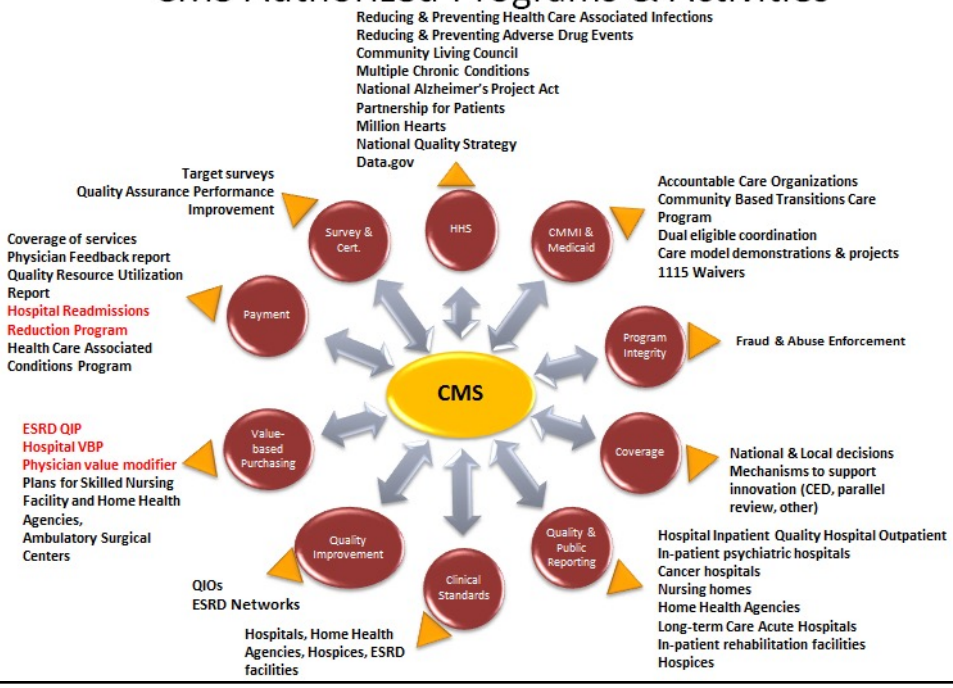
CMS Authorized Programs & Activities



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Summary of FY24 Measures

Crosswalk to Payers & Programs

Measure	Vizient Q&A	CMS HAC	CMS-VBP	CMS Star Ratings	HQIP	Magnet	Leapfrog
Falls with Injury Rate						X	
PSI-03 Pressure Injuries	X	X		X		X	X
CLABSI SIR	X	X	X	X		X	X
CAUTI SIR	X	X	X	X		X	X
C-DIFF SIR	X	X	X	X	X		X
Hypoglycemia in Insulin Use	X						
SSI Colon	X	X	X	X			
SSI Hyst	X	X	X	X			
PSI-09 Post-op Hemorrhage or Hematoma	X	X		X			X
PSI-11 Post-op Respiratory Failure	X	X		X			X
PSI-12 Perioperative DVT or PE		X		X			X
PSI-13 Post-op Sepsis	X	X		X			X
Mortality	X						
HCAHPS: Responsiveness	X		X	X			X
HCAHPS: Discharge Information	X		X	X	X		X
HCAHPS: Communication about Meds	X		X	X	X		X
Readmissions	X						
Excess Days	X						

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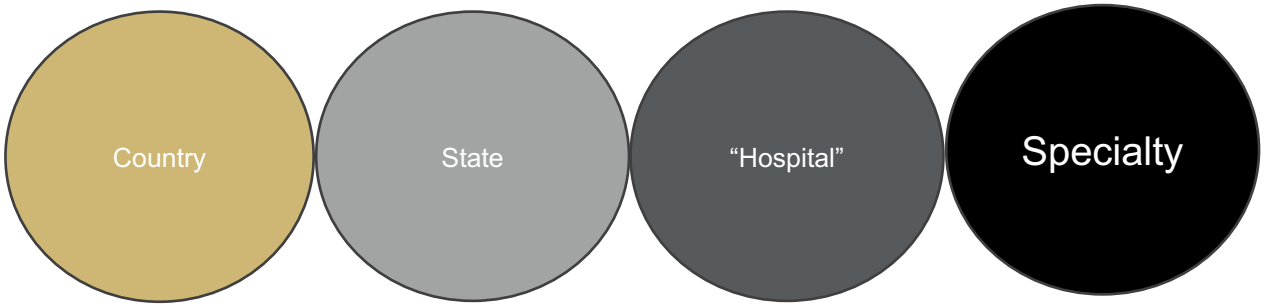
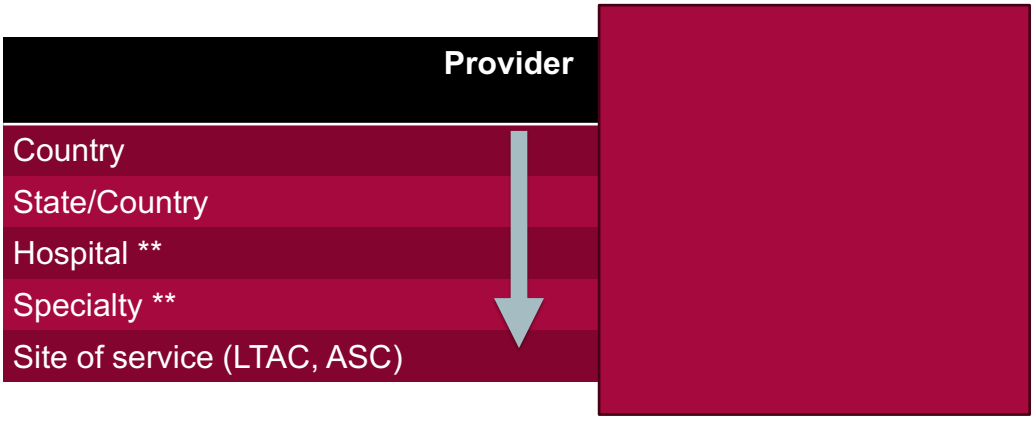
Quality Rankings Perspective

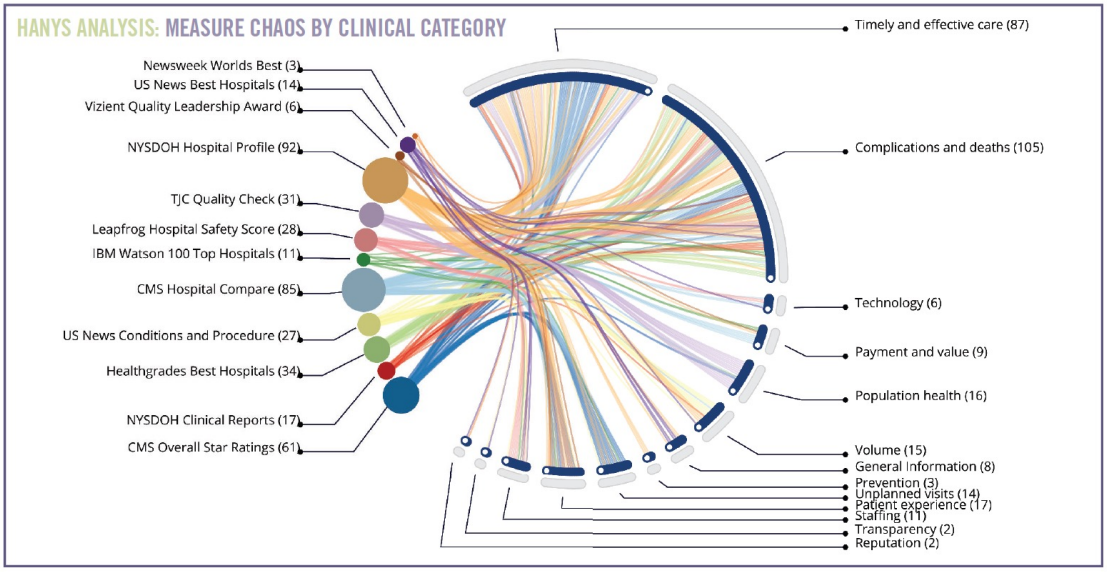


Quality (& Safety) Rankings Perspective



** TIN Dilution

“Popular HC” Q&S Measure Programs vs Measure Domain

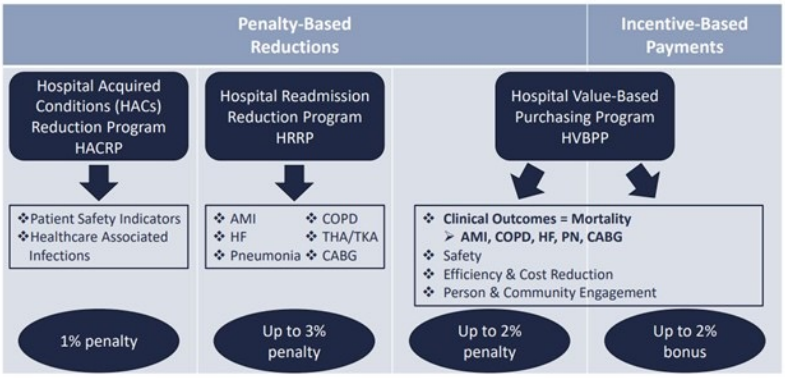


Quick Break Out (3 min)

- Name 3 quality measures that access care in your area?
  - *Do you have data about your area’s performance?*

Financial Impact

Direct Cost / Revenue



Blue Distinction® Center+ Cardiac

Indirect Cost / Revenue

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2022-23

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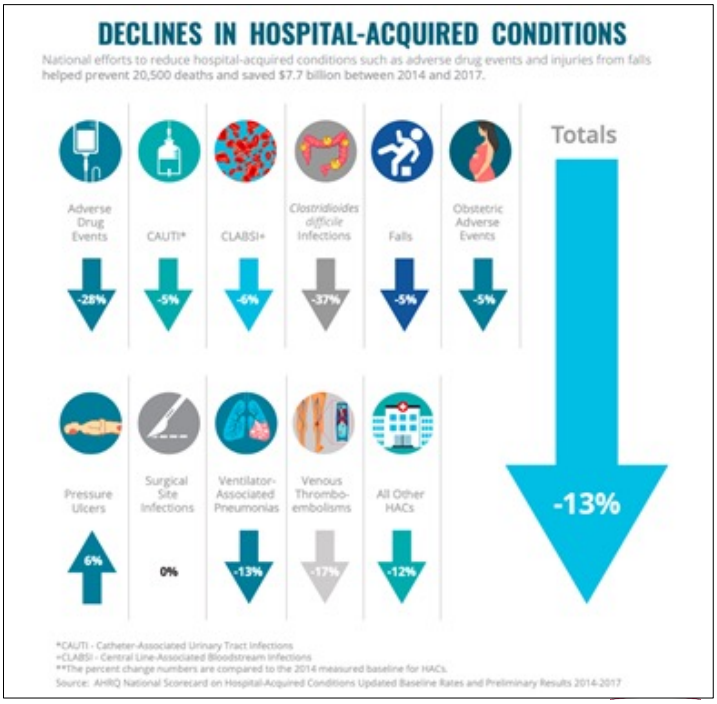
Do Publicly Reported Quality Measures Make A Difference?



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Advisory Board POPULAR EVENTS DAILY BRIEFING Login Create a

Daily Briefing

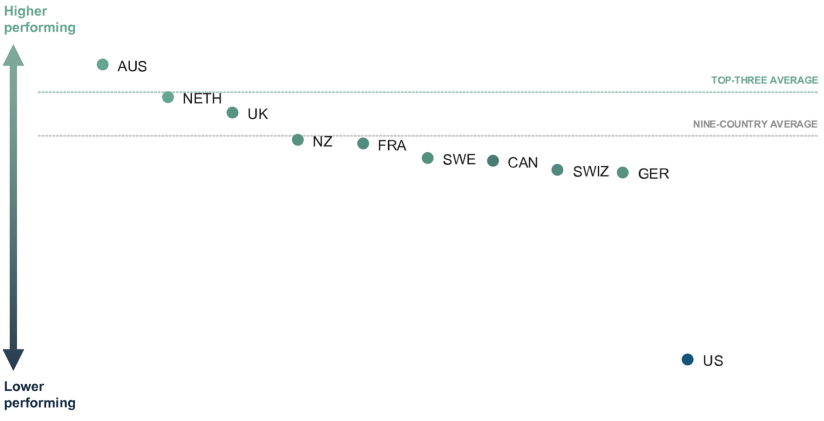
Around the nation: Just 44% of healthcare quality measures have improved since 2000

Posted on March 16, 2023

Updated on March 17, 2023

In the past two decades, only 44% of healthcare quality measures have improved, according to an updated report from the **Agency for Healthcare Research and Quality** (AHRQ), in today's bite-sized hospital and health industry news from California, the District of Columbia, and Maryland.

The United States lags its international peers considerably on health system performance.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

Review > JAMA. 2019 Oct 15;322(15):1501-1509. doi: 10.1001/jama.2019.13978.

Waste in the US Health Care System: Estimated Costs and Potential for Savings

William H Shrank [1], Teresa L Rogstad [1], Natasha Parekh [2]

Affiliations + expand

PMID: 31589283 DOI: 10.1001/jama.2019.13978

"…the estimated cost of waste in the US health care system ranged from $760 billion to $935 billion, accounting for approximately 25% of total health care spending."

Shrank WH, Rogstad TL, Parekh N. Waste in the US health care system: estimated costs and potential for savings. JAMA. 2019;322(15): 1501–9.

It is a challenge …

Additional Reading:

> Health Aff (Millwood). 2025 Feb;44(2):179-186. doi: 10.1377/hlthaff.2024.01007.
Epub 2025 Jan 22.

From Laggard To Leader: Why Health Care In The United States Is Failing, And How To Fix It

Donald M Berwick [1], Elaine Batchlor [2], Dave A Chokshi [3], Patricia Gabow [4], Richard Gilfillan [5], Frederick Isasi [6], Arnold Milstein [7], Len M Nichols [8]

Affiliations + expand

PMID: 39841945 DOI: 10.1377/hlthaff.2024.01007

"…we present a partial road map for transforming the US health care system. We propose bold national goals: affordable and equitable care for all, an additional decade of healthy birthdays after retirement, elimination of racial and ethnic disparities in health, substantial reduction in health care expenditures, and, most important, improved health outcomes."

Final thoughts…. 2019-2024

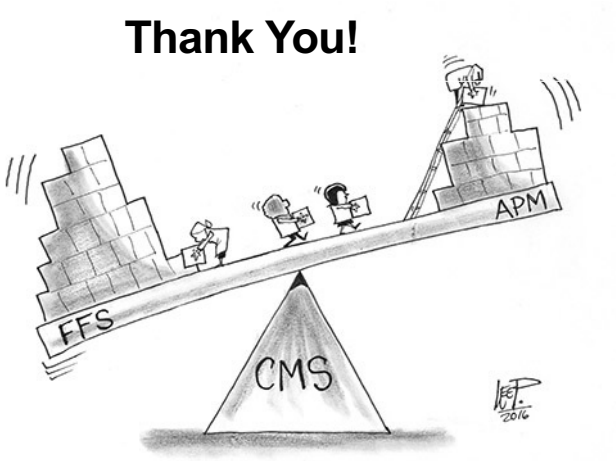
- ☐ Medicare will continue to drive market forces
- ☐ VBP programs have been slow to roll out (ACA repeal, covid)
- ☐ Cost reduction + will be the primary strategy (capitation+)
- ☐ Uninsured and high deductible will be left out
- ☐ There is some innovation in commercial space
- ☐ Mandatory & all payer programs need to be created to truly evaluate the impact of VBP programs on patient outcomes
- ☐ There is still opportunity to develop meaningful patient-centered process and outcome measures

Final thoughts…. 2019-2024 Now

- ☐ Medicare will continue to drive market forces
- ☐ VBP programs have been slow to roll out (ACA repeal, covid)
- ☐ Cost reduction + will be the primary strategy (capitation+)
- ☐ Uninsured and high deductible will be left out
- ☐ There is some innovation in commercial space
- ☐ Mandatory & all payer programs need to be created to truly evaluate the impact of VBP programs on patient outcomes
- ☐ There is still opportunity to develop meaningful patient-centered process and outcome measures

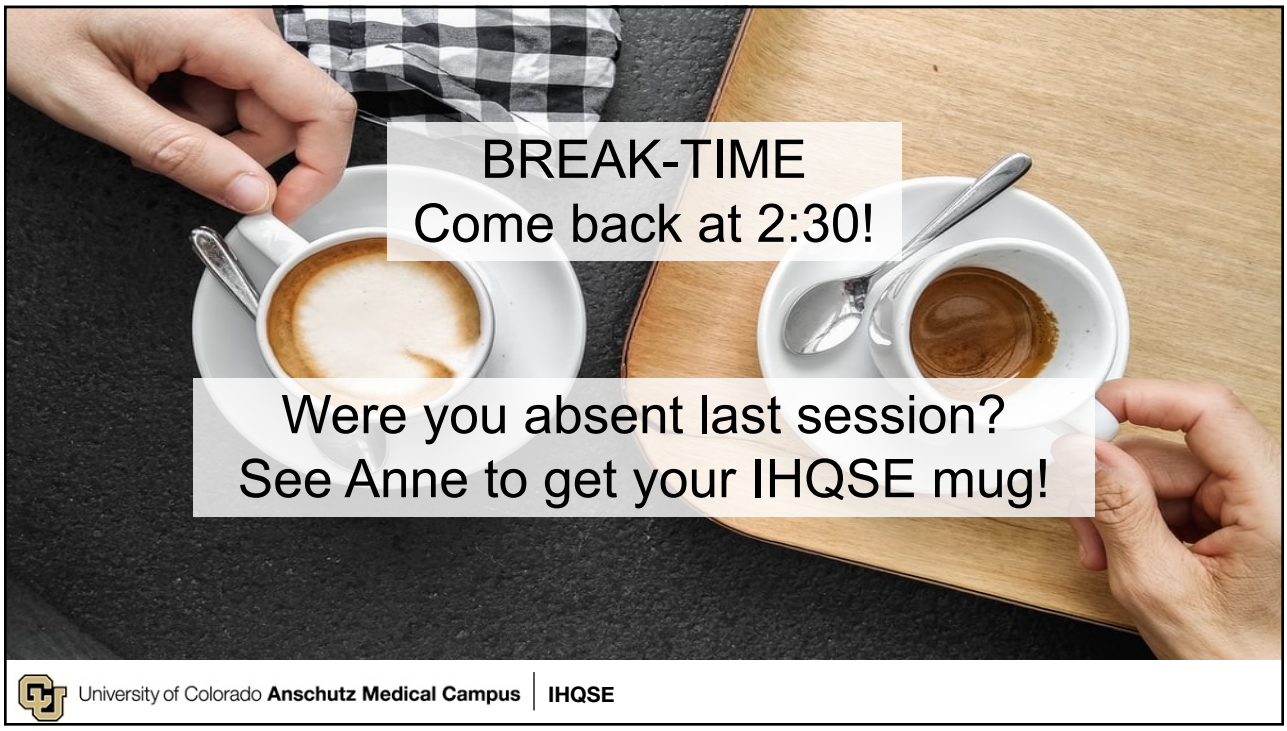
- ☐ **Commercial payer +** Medicare will drive market forces
- ☐ VBP programs **will shut down or growth stop**
- ☐ Cost reduction + will be the primary strategy (capitation+)
- ☐ Uninsured and high deductible will be left out
- ☐ Innovation **will focus on cost containment from Medicaid losses**
- ☐ Mandatory & all payer programs **will not exist**
- ☐ There is still opportunity to develop meaningful patient-centered process and outcome measures **but there will be little enforcement/program creation to use them**

Thank You!



Jennifer.Wiler@cuanschutz.edu
@DrJenniferWiler

Evaluation



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Complexity vs. Chaos

Leadership and Teams

Patrick Kneeland, MD
SFHM

VP of Medical Affairs
@DispatchHealth

Assistant Clinical Professor
of Medicine

Institute for Healthcare Quality, Safety and Efficiency
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

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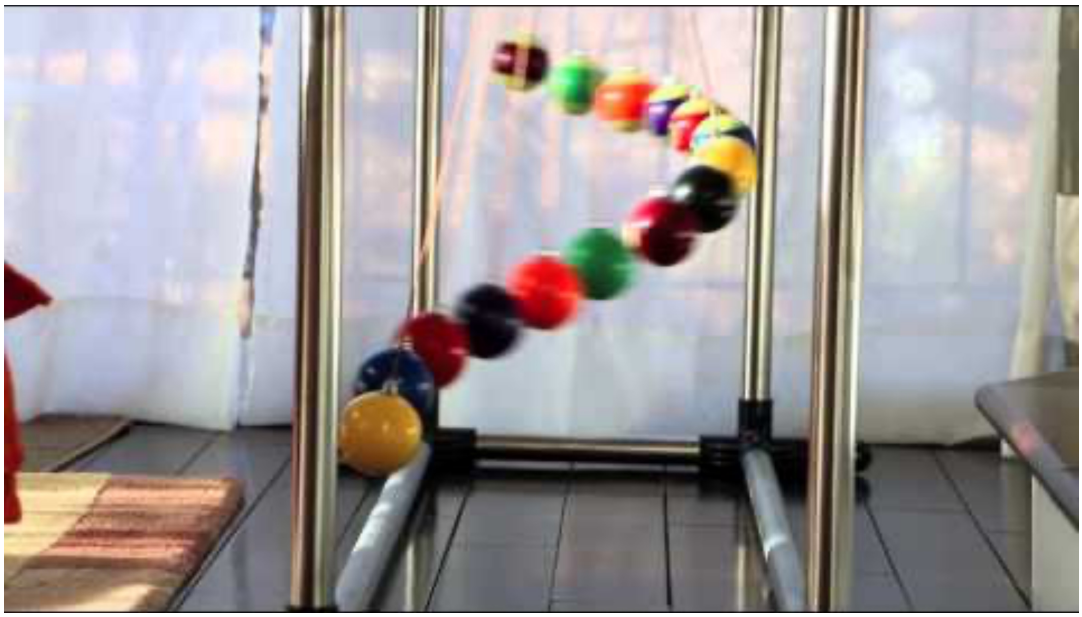
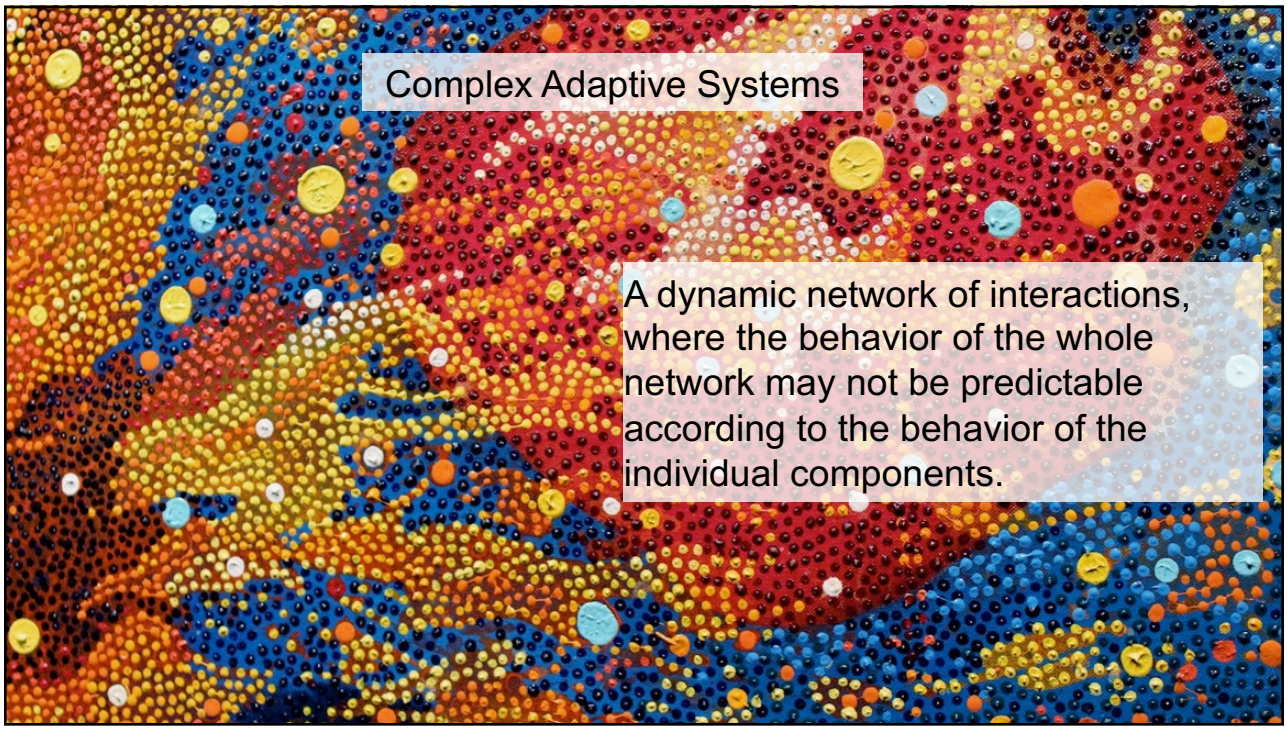


Complex Adaptive Systems

Nonlinear interactive components,
Emergent phenomena,
Continuous and discontinuous change,
and Unpredictable outcomes

Uncertainty and paradox are inherent



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simple	complicated	complex
		
Inputs and outputs are known; a simple set of rules can be applied Examples: Baking a cake Pre-procedural time-out Selecting the right antibiotics Interventions: Recipes, checklists, charts	Substantial uncertainties; solutions not known but are potentially knowable Examples: Designing a rocket ship to fly to the moon Performing open heart surgery) Interventions: Formulas, algorithms	We have a sense of what works, but the actual formula remains unknowable Examples: Raising a child Engaging staff to perform time-out 100% of the time Improving patient experience Interventions: Formulas have limited utility Rules and policies stifle innovation Rapid cycles of innovative change needed

Adapted from Wachter, Understanding Patient Safety, 2012

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simple	complicated	complex
		
Inputs and outputs are known and a simple set of rules can be applied (baking a cake, pre-procedural time-out, selecting the right antibiotics for a common infection)	Substantial uncertainties; solutions aren't known but they are potentially knowable (designing a rocket ship to fly to the moon, performing open heart surgery)	We have a general sense of what works, but the actual formula for success remains unknowable (raising a child, engaging the medical staff to reliably perform time-out 100% of the time, improving patient experience, creating a healthy workplace culture)
Recipes, checklists, charts	Formulas, algorithms	Formulas have limited utility, rules and policies may actually stifle innovation; rapid cycles of innovative change

Adapted from Wachter, Understanding Patient Safety, 2012

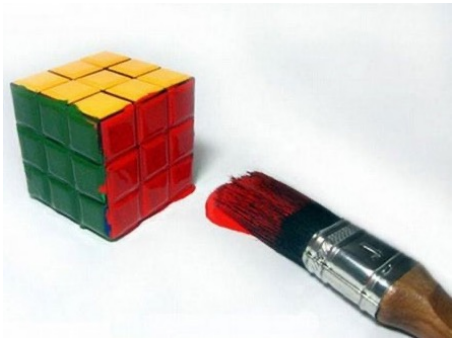
- What are some examples of complex adaptive systems that you see in your daily work experience?
- What does an effective leader do in a complex system/organization?

We have a general sense of what works, but the actual formula for success remains unknowable

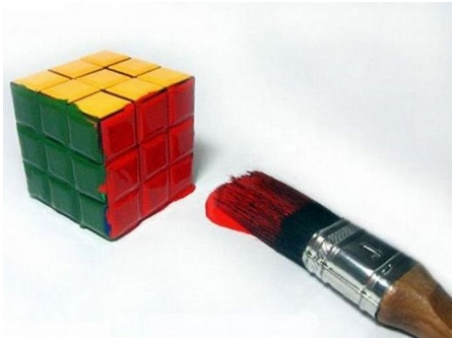
(raising a child, engaging the entire medical staff, creating a healthy workplace culture)

Formulas have limited utility, rules and policies may actually stifle innovation; rapid cycles of innovative change

Adapted from Wachter, Understanding Patient Safety, 2012



Seek simplicity but don't trust it.



Seek simplicity but don't trust it.

Beware of this phrase:
"Why don't we just . . .?"

Levers for transformation


Individual Practices


Team Practices


Leadership Practices


System (re)Design

Leadership Tools to Leverage in Amid Complexity

Prioritizing “sense-making”

Doubling down on clarity where it exists

Acknowledging and managing polarities

Building culture by practicing behaviors individually and collectively

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Prioritize “Sense-Making”

Deliberately connecting the dots for people through story and data

- For example:
  - Let’s take a minute to examine how we got here
  - I want to share some data that may shed some light on where the bottle neck is
  - There is a lot we have to explore further, what do we know for sure?

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Double-down on clarity around the things that are certain (not complex)

- For example:
  - This is the expected daily schedule for our interdisciplinary clinical teams
  - You are expected to complete the sign out document at the end of every shift before you leave
  - This is the field guide for care logistics
  - This is the reporting structure
  - These are the performance targets and why we are focusing on these
  - These are the dimensions by which your performance will be measured, and this is how we will check in to assess progress and performance

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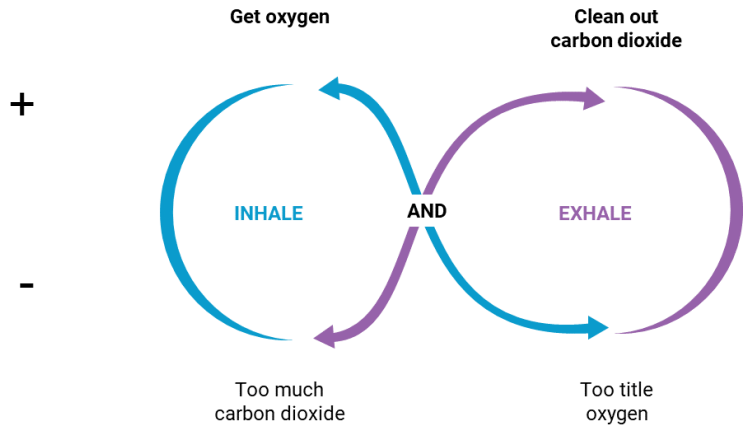
Acknowledge and Manage Polarities

(The Inherent Paradoxes in Complex Systems)

Acknowledge and Manage Polarities

Which is more important in breathing: Inhaling or Exhaling?

Acknowledge and Manage Polarities



Acknowledge and Manage Polarities

What are some polarities that come up frequently in our healthcare environments?

Acknowledge and Manage Polarities

- Safety and Efficiency
- Education and Cost effectiveness
- Quality and Cost of Care
- Patient Experience and Cost of Care
- Reliability/consistency and Personalized/customized care
- Tried & true and Innovation
- Tradition and Modernization (ie, in education and training)
- Transparency and Privacy
- Lead-time and Flexibility (ie, in clinical schedule)

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Be deliberate about Culture Building

The role of "Culture"
in complex adaptive systems

GENERATIVE
Organization/team wired for continuous learning and improvement

PROACTIVE
Planning ahead using leading indicators, anticipating, solving problems

SYSTEMATIC
Consistent systems in place to fight fires

REACTIVE
Ad hoc fire-fighting – reacting to lagging indicators

UNMINDFUL
No awareness of need to improve

adapted from Michael Leonard MD at Safe and Reliable Care and Prof. Patrick Hudson, Univ. Leiden

Where do we live most of the time?

How do these various models of culture land in the world of complex systems?

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University of Colorado **Anschutz Medical Campus** | **IHQSE**

Culture = Behavior over time

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Culture = Behavior over time

What behaviors?

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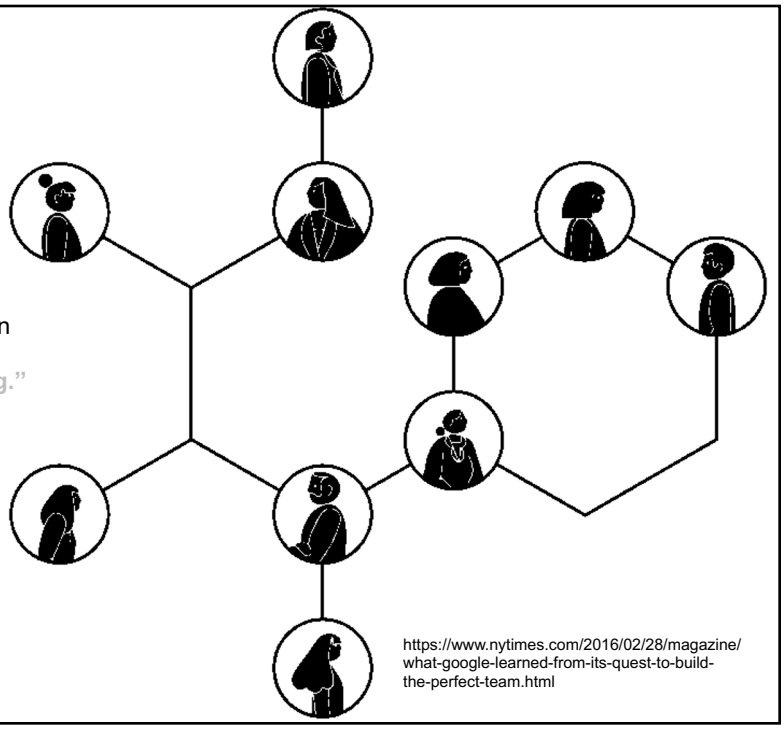
The Surprising Science of High Functioning Teams:

1. On the good teams, members spoke in roughly the same proportion, a phenomenon the researchers referred to as **"equality in distribution of conversational turn-taking."**

2. The good teams all had **high "average social sensitivity"** — a fancy way of saying they were skilled at intuiting how others felt based on their tone of voice, their expressions and other nonverbal cues.



https://www.nytimes.com/2016/02/28/magazine/what-google-learned-from-its-quest-to-build-the-perfect-team.html

The #1 characteristic of leaders of highly functioning teams at google was . . .

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Willingness to demonstrate vulnerability . . .

Behavior Practice 1: Powerful Questions

For most people,

? = Good

. = !

Why?

Powerful Questions

1. Open-ended
2. Non-judgmental
3. Answer is unknown to you
4. Exploratory

Behavior Practice 2: Learning-focused Debrief

1. What went well?
2. What did we learn?
3. What would we do differently next time?

Behavior Practice 3: Inviting and Sharing Story

Behavior Practice 4: Appreciation

Building a Generative Culture

Powerful Questions

Inviting story

Learning-focused debrief

Appreciations
(start with appreciative debrief)

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Pro Tips

Start with practicing 1 or 2 of these first.

1. Powerful questions before jumping to solutions or assuming everything is already known
2. Appreciation – hardwire it into existing structures like huddles or staff meetings
3. Name Polarities when you see them: “Could it be that what we are circling around here is a polarity – where both things are true and valuable?”
4. Sharing Stories especially of a time when you found something difficult or “failed” and learned from it

Leading through Complexity: Summary

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That is hard.

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We do most of our work and are leading change and improvement efforts in complex adaptive systems.

That is hard.

Deliberate approaches to leading through complexity include:

- Prioritizing “sense-making”
- Doubling down on clarity where it exists
- Acknowledging and managing polarities
- Building culture by practicing behaviors individually and collectively

Unconscious Bias & Being an Upstander

David A. Mafe
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Institute for Healthcare Quality, Safety and Efficiency
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

The Office of Diversity, Equity, and Inclusion

To close the **gap** between what **we say** about ourselves and the **lived experience** of patients, staff, and the communities that we serve.

To build our workforce in such a way that we can meet our mission of **Improving Lives** both now and into the future.

DEI - Defined

STANDARD DEFINITION

- **D = Diversity:** Is the presence of different types of people from a wide range of identities with different perspectives and experiences.
- **E = Equity:** Aims to identify and eliminate barriers that prevent the full participation of some groups. It means everyone is given equal treatment and access to opportunities for advancement.
- **I = Inclusion:** Means that everyone feels a part of their team and the larger organization, no matter what their identity. Inclusion is diversity in action.

WORKING DEFINITION

- D = Diversity: Is a fact.
- E = Equity: Is the work.
- I = Inclusion: Is a choice.

What is Unconscious Bias?

- Attitudes or stereotypes that affect our **understanding, actions, and decisions** in an **unconscious** manner. There are hundreds of different types of biases.
- Formed on a wide range of subjects including gender identity, race, appearance, socioeconomic status, weight, sexuality and more. They are based on an **individual's experiences and history.**
- We **instinctively categorize people** based on observed criteria to save mental energy. This allows us to focus more easily on other tasks.

Our unconscious bias can drive our interactions with our teams, patients, their families, and each other.

If in healthcare, we improve lives,
how might bias impact our ability to live up to this goal?

Reflecting on your own leadership style, how do you ensure objectivity in decision making?

What are some of your specific practices in encouraging a culture that challenges assumptions and biases?

Being an Upstander

Upstander vs. Bystander

Bystander

An individual that observes or knows about incivil behavior but takes no action.

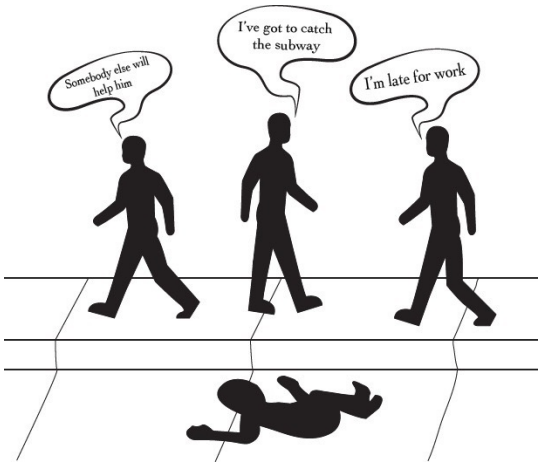
Upstander

An individual that observes or knows about incivil behavior and ***then takes action to make it right***.

Why Be an Upstander

Bystander Effect: a social psychological theory where individuals are less likely to offer help to a victim when there are other people present.

How do you think the bystander effect might impact group dynamics and decision-making processes within our organization?



The Three D's of Being an Upstander:

Determine the correct action to take as an Upstander and apply these behaviors:

- **Direct:** A direct intervention is exactly as it says; a bystander confronts a situation. When safe, being direct is the most immediate way to intervene in a situation.
- **Distract:** Perhaps you don't want to address a situation directly then you can try to cause a distraction that will diffuse the situation and give a moment for things to calm down.
- **Delegate:** If you can't intervene directly in something because there is a barrier that makes you uncomfortable, then enlist some help.

Always remember to **check-in** with the individual (patient or staff) impacted by the behaviors.

Ways to check-in:

- Acknowledge to the person who received the incivility that it was unacceptable and ask how they are doing.
- Follow-up with the individual and let them know if action was taken with the microaggressor.
- Ask if there is anything they need and let them know you are there for them.

Examples of the 3 D's

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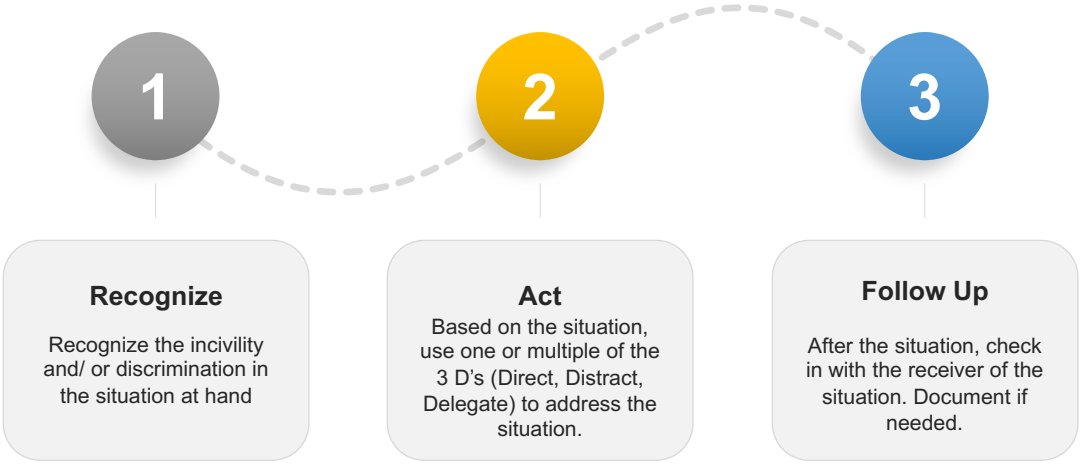
Being an Upstander: Review



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Scenario Application

Scenario Discussions

After reading your scenario, determine the correct action to take as an Upstander and apply these behaviors:

What action would you take per the 3 "Ds"?

- **Direct**; **Distract**; **Delegate**

What words might you use?

What is the most appropriate next step?

Group Discussion

Scenario 1 Discussion

Sarah, a 35-year-old African American woman, has been receiving treatment for a chronic health condition at a local healthcare clinic for the past few months.

a. During her most recent visit, you witness the following:
   i. Sarah waits a longer time than usual for service.
   ii. Staff members who are typically very attentive to patients, ignore Sarah and then become visibly agitated when she asks questions.
   iii. Sarah seems defeated by these interactions.
b. What actions do you take and why?
   i. Direct, Delegate, Distract.
   ii. What words might you use with the patient or members of the team?
   iii. What is the appropriate next step?

Scenario 2 Discussion

A female attending physician accompanies her resident for a team meeting about the patient's care. The meeting includes some of the bedside nursing team who disagree with the current plan of care as it relates to goals of care. When in discussion, the attending physician notices that the male nurse makes little eye contact when she is speaking and continues to redirect their conversation to the male resident on the team.

a. As the attending, what actions do you take and why?
    i. Direct, Distract, Delegate.
b. The attending, delegates this situation to you, the nurse manager. How will you approach this conversation with the nurse? What words will you use?
c. During the conversation, the bedside nurse says, "I don't have a bias against women providers—my daughter wants to go to medical school!" How would you respond?

Scenario 3 Discussion

During morning rounds at the hospital, Dr. Smith leads a team of medical residents to review patient progress. As the team enters Sam's room, Dr. Smith assumes Sam's gender based on their appearance and addresses Sam using their birth name and repeatedly refers to them as "he," even after Sam has corrected him. You can see that Sam is feeling uncomfortable and seems hesitant to address the doctor in front of the team.

1. What actions do you take? Why?
    i. Direct, Delegate, Distract.
2. What words might you use with the resident, patient or physician?
3. What is the most appropriate next step?

Debrief Questions

- How do you feel talking about these situations?
- What barriers do you feel you may face when being an Upstander?
- How can you best support your team in acting as Upstanders?

Resources

Unconscious Bias Resources:

Franklin Covey Unconscious Bias Self-Assessment

Combat Bias Activity Cards

Uncovering Unconscious Bias for Leaders: Pamela Fuller, Mark Murphy, and Anne Chow

LinkedIn Learning:

Addressing Unconscious Bias as a Leader

Uncovering Unconscious Bias in Recruiting and Interviewing

From Bystander to Upstander

Communicating about Culturally Sensitive Issues

Strategies to Foster Inclusive Language at Work

Appreciative Debrief

Share with the group one thing you found most intriguing from this session

Next Steps

- Due April 22 –
  - Create a series of short-term wins to support your project
  - Update data plan to include current state data

Date Assigned	Assignment	Due Date
#13 – Feb. 11, 2025	• Create plan for removing barriers to success	#15 – Mar. 11, 2025
#14 – Feb. 25, 2025	• No new assignments	
#15 – Mar. 11, 2025	• No new assignments	
#16 – April 1, 2025	• Create series of short-term wins to support project • Update data plan to include current state data	#18 – Apr. 22, 2025
#17 – Apr. 8, 2025	No new assignments	
#18 – Apr. 22, 2025	• Develop plan for sharing/spreading your work	#21 – June 10, 2025
#19 – May 13, 2025	• Plan for putting project into embed phase • Develop final report out	#20 / #21 – May 27 / June 10, 2025
#20 – May 27, 2025	No new assignments	
#21 – June 10, 2025	No new assignments	
#22 – June 24, 2025	No new assignments	

Evaluation

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