The Role of the Compliance Department in Today’s Challenging Quality Measurement Reporting Environment

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Today’s speakers

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Measuring the Value and Quality of Care

Why focus on quality reporting?
Measuring the Value and Quality of Care

Increased Focus on Quality Reporting

Healthcare quality and efficiency measures are used by federal and state regulatory agencies, as well as others, to determine the effectiveness of an organization's patient care delivery.

To hospitals, increased attention on quality reporting provides:
- Insights as to gaps for internal improvement
- Differentiation to customers
- Higher revenues for higher quality services
- A need for credible, relevant, complete and accurate quality measures

Clear evidence of the reliability of quality measures is, and will be, increasingly important as the focus on the financial impact of quality outcomes to healthcare organizations increases.

Measuring Quality of Care Today

CMS Quality Reporting Programs & Quality Initiatives

Continued Innovation through the Quality Payment Program

Medicare Access and CHIP Reauthorization Act (MACRA)
Quality Payment Program (QPP)
Medicare Incentive Payment System (MIPS)

Medicare Incentive Payment System (MIPS)
### MIPS Reporting

#### Data Submission Mechanisms

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Individual Reporting</th>
<th>Group Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>QCIR</td>
<td>QCIR</td>
</tr>
<tr>
<td></td>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
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<tr>
<td></td>
<td>EMIR</td>
<td>EMIR</td>
</tr>
<tr>
<td></td>
<td>Administrative Claims (as submission required)</td>
<td>CMS approved survey vendor for CMS for MIPS</td>
</tr>
<tr>
<td></td>
<td>Claims</td>
<td>Claims</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Resource Use</strong></th>
<th>Administrative Claims (as submission required)</th>
<th>Administrative Claims (as submission required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QCDR</td>
<td>QCDR</td>
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<tr>
<td></td>
<td>Qualified Registry</td>
<td>Qualified Registry</td>
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<tr>
<td></td>
<td>EMIR</td>
<td>EMIR</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface (group of 25 or more)</td>
<td>CMS Web Interface (group of 25 or more)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Advancing Care Information</strong></th>
<th>Administrative Claims</th>
<th>QCDR</th>
<th>Qualified Registry</th>
<th>EMIR</th>
<th>CMS Web Interface (group of 25 or more)</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Administrative Claims</td>
<td>QCDR</td>
<td>Qualified Registry</td>
<td>EMIR</td>
<td>CMS Web Interface (group of 25 or more)</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities</strong></td>
<td>Administrative Claims</td>
<td>QCDR</td>
<td>Qualified Registry</td>
<td>EMIR</td>
<td>CMS Web Interface (group of 25 or more)</td>
</tr>
</tbody>
</table>

### Overview of the CMS Star Rating Methodology for Providers

1. Select Measures
2. Group Measures
3. Calculate Group Score
4. Generate Summary Score
5. Calculate Star Ratings
Step 1: Selecting and Standardizing Measures

Quality measure results include many different types of scoring information (e.g., times, percentages, rates) and therefore need to be:

- Standardized
  - By calculating a z-score for each measure, the measures become comparable
  - The difference between an individual hospital’s score and the overall mean score for all hospitals divided by the standard deviation for all hospitals

- Adjusted for Outliers (Winsorization)
  - Set all scores to within 3 standard deviations of the mean

Source: CMS.

Step 2: Group Measures (as of July 2016)

<table>
<thead>
<tr>
<th>Mortality Measures (7 measures)</th>
<th>Safety of Care Measures (9 measures)</th>
<th>Readmission Measures (7 measures)</th>
<th>Patient Experience Measures (11 measures)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

These seven groups of measures are closely aligned with the Value-based Purchasing Program and the categories included on Hospital Compare.

By grouping measures into these categories, it will allow specific measures within the groups to be added or removed from the star ratings in the future.

Source: CMS.

Step 3: Calculate Group Scores

CMS uses an analytical concept called Latent Variable Models to calculate each group score. The reasons that these models are used are because:

- Quality of care is hard to define variable to predict
- Each hospital may report different amount of cases in each measure
- Measure with larger amounts of cases are easier to predict overall quality of care

Examples of latent variables from the field of economics include:
- quality of life
- business confidence
- income
- happiness and conservatism

These are all variables which cannot be measured directly. But linking these latent variables to observable variables, the values of the latent variables can be inferred from measurements of the observable variables.

Quality of life is a latent variable which cannot be measured directly. Observable variables are used to infer quality of life.

Observable variables to measure quality of life include:
- wealth
- employment
- earnings
- physical and mental health
- education
- recreation and leisure time
- social belonging

Source: CMS.
Step 4: Generate Summary Score

The following criteria were used to determine weighting:
- Measure importance
- Consistency
- Policy Priorities
- Stakeholder input

Weight Average: Hospital Summary Score

Step 5: Assigning a Star Rating

CMS uses a statistical concept called k-Means clustering to translate each hospital's weighted score into an overall star rating:

- Two random data points are selected and the distance between these points and all other points is calculated to see which one is closer to (in the case of the star ratings, they select 5 points)
- The average distance from these points to all other points in the group is calculated and becomes the new central point
- This process is iterated until the central points are determined to be the minimum distance between the central point and all points within that group

Source: CMS.

Step 5: Assigning a Star Rating

<table>
<thead>
<tr>
<th>Rating</th>
<th>Number of Hospitals</th>
<th>Percentage of Hospitals</th>
<th>Summary Score Range in Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>100</td>
<td>2.73%</td>
<td>(0.85, 2.06)</td>
</tr>
<tr>
<td>4</td>
<td>918</td>
<td>25.10%</td>
<td>(0.23, 0.85)</td>
</tr>
<tr>
<td>3</td>
<td>1,777</td>
<td>48.58%</td>
<td>(-0.35, 0.23)</td>
</tr>
<tr>
<td>2</td>
<td>728</td>
<td>19.90%</td>
<td>(-1.00, -0.35)</td>
</tr>
<tr>
<td>1</td>
<td>135</td>
<td>3.69%</td>
<td>(-1.97, -1.01)</td>
</tr>
</tbody>
</table>

Source: CMS.
The star ratings are aligned with incentive payments tied to the underlying measures

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Average HAC % ( Penalty / Reward )</th>
<th>Average VBP % ( Penalty / Reward )</th>
<th>Average Readmission % ( Penalty / Reward )</th>
<th>Total Average % ( Penalty / Reward )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(0.5)%</td>
<td>(0.5)%</td>
<td>(0.1)%</td>
<td>(1.8)%</td>
</tr>
<tr>
<td>2</td>
<td>(0.3)%</td>
<td>(0.2)%</td>
<td>(0.1)%</td>
<td>(1.2)%</td>
</tr>
<tr>
<td>3</td>
<td>(0.2)%</td>
<td>(0.2)%</td>
<td>(0.7)%</td>
<td>(1.1)%</td>
</tr>
<tr>
<td>4</td>
<td>(0.2)%</td>
<td>0.2%</td>
<td>(0.4)%</td>
<td>(0.8)%</td>
</tr>
<tr>
<td>5</td>
<td>0.2%</td>
<td>0.5%</td>
<td>(0.1)%</td>
<td>0.7%</td>
</tr>
<tr>
<td>6</td>
<td>0.1%</td>
<td>1.0%</td>
<td>(0.2%)</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Understanding the Quality Reporting Program

General Program Decomposition and Key Questions

Key Questions

- What are the clinical documentation, checklist and evidence-based protocols/guidelines that are followed?
- What are the sources of information for the EMR (electronic medical record)?
- Does the EMR platform support the quality reporting program?
- Is there an opportunity for EMR implementation/upgrade?
- Is there a quality reporting analytics tool?
- Are there automated processes (workflow or automated aggregation and calculation capabilities)?
- Are reporting guidelines and definitions followed?
- Is there data transparency?
- Are data hierarchies aligned to the business and reporting structure?
- Are reporting cycles as efficient as possible?
- Are current reports providing adequate business value and achieving reporting requirements?
- Are there data or information sharing capabilities?
- Is there an adequate control mitigating business risk?
- Do gaps and overlaps optimally fit within established key processes?
- Are there data or information sharing capabilities?
# Governance, Risk & Control Tools

## Overview of Internal Audit Project Approach

**Collaboration Plan with Compliance**

Performance-based Quality Reporting represents a key process whereby events are recorded and compiled for internal and external reporting, compliance and analysis purposes. The major phases of the Quality Reporting Process are as follows:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Planning</td>
<td>A systematic method used to identify the organization’s long-term goals and to lay out the best approach for achieving those goals. This includes resource projections for key initiatives supporting the organization’s strategy. Planning encompasses both external and internal factors that span the entire organization.</td>
</tr>
<tr>
<td>Program Scoping</td>
<td>The process whereby an organization’s strategic plan is translated into specific quality targets. The level of detail tends to be greater than in planning activities. Once in place, budgets are compared against actual results and specific accountabilities are typically established at various levels within the organization.</td>
</tr>
<tr>
<td>Execution Management</td>
<td>The process of combining and displaying/distributing periodic business results for analysis—these results are made available to management to validate strategy, measure performance and guide business decision making.</td>
</tr>
<tr>
<td>Process Governance</td>
<td>Includes program capability management as well as oversight, tracking and day-to-day management activities, including implementing and maintaining a formal continuous improvement program. Also includes managing system maintenance for the IT systems used for quality reporting.</td>
</tr>
</tbody>
</table>

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**Understand the Quality Reporting Program**

**Process Decomposition – Key Phases Defined**

**Performance-based Quality Reporting**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define Detailed Project Scope &amp; Document Process, Risks, and Controls</td>
<td>Identify &amp; Evaluate Internal Control Activities</td>
</tr>
<tr>
<td>Conduct owner interviews to confirm understanding of program objectives, initiatives, key roles &amp; responsibilities, etc.</td>
<td>Conduct a gap analysis of key quality reporting program and process-level risks</td>
</tr>
<tr>
<td>Confirm quality reporting program understanding including key business process documentation, process-level risks, control activities (including IT focus) with project sponsor / stakeholder(s)</td>
<td></td>
</tr>
</tbody>
</table>

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Clinical Controls

Assumptions and Our Viewpoints

Assumptions
— All hospitals focus on and report on “quality”, but the approaches, priorities, definitions, and reporting differ across the country
— The hospital strategic goals are aligned to the quality reporting objectives

Viewpoint #1 – The Core Metrics
A core number of measurable outcomes are consistent across the major quality reporting services and will drive a large portion of real value in the future

Why does this matter?
- Improved patient outcomes
- Enhanced reputation and brand for clinical quality
- Improved reimbursement through CMS value-based payment and other state-specific measures
- Opportunities for physician alignment through shared savings and pay-for-outcome performance models

Viewpoint #2 – Clinical Data Integrity
Regardless of the measures chosen, the underlying data may not support the reported “quality”, which can have various implications for hospitals

Why does this matter?
- Assurance around appropriateness of reporting
- Enhanced compliance under increased regulatory scrutiny

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Clinical Controls

Major Quality Outcomes Measurement Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Source of Data</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid</td>
<td>Standardized reporting on hospital resources, process, and outcome data</td>
<td>National outcomes reporting on hospital resources, process, and outcome data</td>
</tr>
<tr>
<td>The Joint Commission</td>
<td>Standardized reporting on hospital resources, process, and outcome data</td>
<td>National outcomes reporting on hospital resources, process, and outcome data</td>
</tr>
<tr>
<td>Various Specialty Area or Clinical Area Accreditations</td>
<td>Standardized reporting on hospital resources, process, and outcome data</td>
<td>National outcomes reporting on hospital resources, process, and outcome data</td>
</tr>
<tr>
<td>US News &amp; World Reports</td>
<td>Standardized reporting on hospital resources, process, and outcome data</td>
<td>National outcomes reporting on hospital resources, process, and outcome data</td>
</tr>
<tr>
<td>LeapFrog</td>
<td>Standardized reporting on hospital resources, process, and outcome data</td>
<td>National outcomes reporting on hospital resources, process, and outcome data</td>
</tr>
</tbody>
</table>

Hospital Safety Score published annually to consumers
- Maternity Care
- High Risk Surgeries
- In-hospital complications
- Resource Use

Source of Data:
- Leapfrog Survey
- AHRQ Patient Safety Indicators
- CMS data
- AHA Survey

Multiple mandated regulatory reporting that include Hospital Compare, Value Based Purchasing, Hospital Acquired Conditions, Readmission
- Reportable patient outcome data
- Reportable process measures
- Hospital operational data

Source of Data:
- Various government required reporting methods
- Healthcare organization self reports
- Agency conducts site visits on a routine schedule

Clinical Controls

Heightened Transparency
Aligning the Quality Vision

A CASE STUDY – Mitigation of Risk

Case Study: Large Academic Medical Center

Observations – The Core Metrics
— A review of national state quality ranking program methodologies reflect the most consistently used outcomes are mortality and readmission measures for AMI, Heart Failure, and Pneumonia.
— Patient safety and hospital-acquired conditions are key indicators which influence mortality and readmission measures
— Caveat: Based on a review of the rating methodologies and a cursory review of Medicare claims data

Observations – Clinical Data Integrity
— Metrics used to measure quality outcomes appear to be directly related to a hospital’s ability to accurately reflect co-morbidities (through secondary diagnoses) and present-on-admission status of the patient while in the hospital.
— Analyses related to large academic medical center Medicare claims data indicates the potential that the claims data does not support medical centers high-acuity patient population

Case Study: Supporting Analysis – Observation on the Core Metrics

<table>
<thead>
<tr>
<th>Category</th>
<th>Purchasing / HSCRC Quality</th>
<th>Leapfrog</th>
<th>Healthgrades</th>
<th>USNWR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Survival</td>
<td>Yes</td>
<td>Yes 30 day mortality for AMI, Heart Failure and Pneumonia</td>
<td>Yes 30 day mortality for AMI, Heart Failure and Pneumonia</td>
<td>Yes 30 day mortality risk adjusted by specialty</td>
</tr>
<tr>
<td>In-hospital complication s</td>
<td>Yes 30 day mortality for AMI, Heart Failure and Pneumonia</td>
<td>Yes Consist of measures around 14 specialty areas</td>
<td>Yes Consist of measures around 9 post-surgical complications</td>
<td>No 14 specialty areas</td>
</tr>
<tr>
<td>Patient Safety Indicators</td>
<td>Yes Composite score of 65 PSI 6 or weighted aggregate score</td>
<td>Yes Consist of measures around 15 preventable complications</td>
<td>Yes Consist of measures around 9 post-surgical complications</td>
<td>Yes Consist of measures around 5 post-surgical complications</td>
</tr>
</tbody>
</table>
Targeted conditions: Acute Myocardial Infarction (AMI)

Acute Myocardial Infarction (AMI) (aka heart attack): Commonly known as a heart attack, acute myocardial infarction (AMI) occurs when the blood flow that brings oxygen to the heart muscle is severely reduced or cut off completely. This happens because coronary arteries that supply the heart muscle with blood flow can slowly become narrowed from a buildup of fat, cholesterol and other substances that together are called plaque.

Table 1: Quality reporting measures for AMI

<table>
<thead>
<tr>
<th>Quality measure</th>
<th>Weight in composite quality score</th>
<th>Quality domain/weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>NREBT-20 AMI (NQF #0389)</td>
<td>40%</td>
<td>Outcome / 88%</td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Acute/AMI Mortality (NQF #2473)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Survey (NQF #0166)</td>
<td>20%</td>
<td>Patient Experience / 88%</td>
</tr>
</tbody>
</table>

Targeted conditions: Overview of AMI

About 720,000 people in the U.S. suffer heart attacks each year, with an average cost per episode of $24,200.

Complications in cardiac care can lead to increased risk of readmission, length of stay, increases in cost and utilization of resources and mortality.

Risk factors for AMI:
- Age: The majority of people who die of coronary heart disease are 65 or older.
- Smoking
- High LDL cholesterol
- Diabetes

<table>
<thead>
<tr>
<th>AMI</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay (LOS)</td>
<td>4.6 days</td>
</tr>
<tr>
<td>30-day Readmission Rate</td>
<td>19.9%</td>
</tr>
<tr>
<td>Inpatient Cost</td>
<td>$24,200</td>
</tr>
</tbody>
</table>

Source: AMI/PAD; Additional to U.S. Centers and the perspective of hospital readmission paper, 2014

Visualization Across the Continuum

Cardiac care is a continuum of care that includes pre-hospitalization, in-hospital care, and post-discharge care. It is important to ensure that all aspects of care are coordinated and managed effectively to improve patient outcomes. The image illustrates various phases of cardiac care, from pre-hospitalization to post-discharge, highlighting the importance of early diagnosis, timely treatment, and ongoing monitoring.
Acute MI – Documentation and Coding

Non-ST elevation, Non Q-wave, ST elevation MI, Other specified, Unspecified – all terms related to “type” for acute MI

<table>
<thead>
<tr>
<th>Diagnostic Evidence</th>
<th>Treatment and Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Signs, symptoms, and diagnostic criteria for evidence of a possible AMI:</td>
<td>— Anti-thrombotic treatment</td>
</tr>
<tr>
<td>— Chest pain (angina), SOB, “squeezing sensation”, r/v, cough, dizziness, “impending doom”, anxiety, sweating (may be profuse), may have no chest discomfort</td>
<td>— Telemetry monitoring</td>
</tr>
<tr>
<td>— Troponin or Cardiac Enzymes</td>
<td>— Heparin / ASA in combination with platelet inhibitor</td>
</tr>
<tr>
<td>— EKG changes</td>
<td>— Nitrates (Nitroglycerin)</td>
</tr>
<tr>
<td>Visible MI within last 4 weeks</td>
<td>— Beta-Blockers</td>
</tr>
<tr>
<td></td>
<td>— Oxygen</td>
</tr>
<tr>
<td></td>
<td>— MSO4</td>
</tr>
<tr>
<td></td>
<td>— ACE-inhibitors or ARBs</td>
</tr>
<tr>
<td></td>
<td>— Evidence</td>
</tr>
</tbody>
</table>

Case Study: Discussion

Potential Root Cause
Issues in quality reporting of AMI
Clinical documentation supportive of physician treating a possible / probably AMI (as noted by coding rules for “within 4 weeks”) and coded / billed to AMI
— Insufficient communication with physicians, nurses, coding teams
— QI definitions and clinical guidelines without collaboration with CDI
— Diminished importance of clinical documentation process in clinical governance
— Potential for mixed messages to patient on actual diagnoses
— Siloes between existing CDI team and QI resulting in lack of coordinated effort around most impactful measures
Lack of integration of among the clinical, surveillance, and documentation/coding definitions and reporting requirements
Lack of collaboration and knowledge sharing amongst the various teams (e.g. QA/PI, coding, CDI, physicians, infection prevention and control, Marketing)

The Role of the Compliance Department: The Chief Compliance Officer
The Seven Fundamental Elements of an Effective Compliance Program

1. Implementing written policies, procedures and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
7. Responding promptly to detected offenses and undertaking corrective action.

"The Seven Elements of a compliance program are important individually, but are most effective on an interdependent basis." CMS

The Role of the Compliance Officer

Healthcare compliance officers have very important responsibilities in a healthcare organization.

• oversee (usually through a compliance committee) practice and policy standards that can be enforced with disciplinary guidelines that are made known to everyone in the practice.
• address issues concerning individual(s) that have been sanctioned.
  • Including conducting prompt internal investigations, taking corrective action, and reporting findings to the government.
• act as liaisons between the board of directors and the government, playing a major role in deciding what policies the organization adopts.
• create programs on different parts of the compliance program to educate employees and management on the rules so they meet the standards that have been put in place.
• keep up with all the new regulatory rules that are created because organizations may be required to adopt them or to amend the old rules already in place.

Creating A Culture of Compliance

Five Everyday Tips for Compliance

1. Make compliance plans a priority now and continually update as priorities shift.
2. Know your fraud and abuse risk areas by managing process for regulatory updates.
3. Manage your financial relationships.
4. Just because your competitor is doing something doesn’t mean you can or should. Call 1-800-HHS-TIPS to report suspect practices.
5. When in doubt, ask for assistance.
The Compliance Plan

Auditing and Monitoring

— Periodic audits undertaken in order to identify deficiencies in operations, particularly with regard to the claim development and submission process.
— The Corporate Compliance Officer shall establish appropriate procedures for conducting such audits and utilize a risk assessment process to identify and prioritize the areas that pose the greatest risks for compliance violations.
— The Corporate Compliance Officer shall develop an annual audit work plan that lists the risk areas to be audited and monitored for each fiscal year.

Mapping Root Cause

Opportunities for clinical improvement: Establish a standard of care

The standard of care embodies the evidence-based pathway, and requires a process of definition, consensus and approval, and monitoring:

**Define**
- Clarify a pathway: Define evidence-based interventions and medical milestones.

**Obtain Consensus**
- Establish accountability and processes, and formal processes of outreach to ensure compliance.
- Monitor and Follow-up
- Pathway and medical milestones: Audit and evaluate the pathways and medical milestones for the pathways.

Unwarranted variations should be concurrently managed through re-education and re-validation processes.
Emphasizing standards of care: Leading practices for AMI

1. Diagnosis and Assessment: Perform a clinical examination, physical and necessary tests and screening. Obtain electrocardiogram (ECG) and chest X-ray within 24 hours of admission.
2. Treatment Pre-stabilization: Determine if patient needs pharmacological or non-pharmacological treatment. Closely monitor the person's renal function, body weight and urine output during diuretic therapy.
3. Treatment Post-stabilization: Determine if beta-blocker treatment is necessary based on vital signs and symptoms or offer angiotensin-converting enzyme inhibitor. Closely monitor the person's renal function, electrolytes, heart rate, blood pressure and overall clinical status during treatment and ensure that the person's condition is stable for typically 48 hours after starting or restarting beta-blockers and before discharging from the hospital.
4. Post-discharge and Follow-up Care: Schedule a follow-up clinical assessment with a member of the specialist heart failure team within 2 weeks of the person being discharged from the hospital. Continue ongoing management of primary care, including ongoing monitoring and care provided by the multidisciplinary team and communicate information about the patient's condition, treatment and prognosis.

Source: Modified from IHI Clinical Pathway; IHI and other existing materials

Organizational self-assessment

High maturity organizations have a ‘population health’ focus, which means they look beyond their ‘four walls’; these organizations typically consider the following:

- What is our organization’s understanding of the quality metrics that drive payment?
- What are our clinical pathways, order sets, protocols, and metrics that guide patient care through the acute and post-acute episodes of care?
- How do we use patient data from the EHR to facilitate the care of the patient?
- How does the Interdisciplinary Care Coordination process use medical milestones to foster efficient movement and transitions of care, improving quality, and reducing readmissions across all patient care settings?
- How does Clinical Variation Management drive increased quality and safety, improve clinical outcomes, and ensure medically appropriate care and resource utilization?

Q&A

Thank you.