Alegent Health
This is your healthcare

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STATEMENT OF ALEGENT HEALTH MERCY HOSPITAL
SENATE FINANCE COMMITTEE ROUNDTABLE
ON THE
CMS VALUE-BASED PURCHASING PLAN FOR HOSPITALS
MARCH 6, 2008

Alegent Health is the largest not-for-profit, faith-based healthcare system in Nebraska and southwestern Iowa. We are making healthcare better with an exceptional commitment to quality by providing patient focused care for the body, mind and spirit of every person. Alegent Health continues the health ministry begun by its sponsors, Catholic Health Initiatives and Immanuel Health Systems, more than a hundred years ago. At Alegent Health, patients and their families find a continuum of care, from women's and children's services, primary care, wellness counseling, and senior care to cardiovascular services, orthpaedics, oncology, physical rehabilitation, home care and behavioral health.

Alegent Health provides care at more than 100 health service sites in Nebraska and Iowa. We have more than 1,300 physicians on medical staffs. Alegent Health has more than 8,600 employees and more than 2,500 volunteers.

Alegent Health provided in fiscal year 2007 more than $60 million in Community Benefit including care for the poor and underserved, and services and programs to more broadly create healthier communities. We provided over $35 million in direct services to care for the poor which included $16 million in Charity Care to more than 29,000 patients who lacked the means to pay. We provided $25 million towards developing programs and services and participating in community based efforts to create healthier communities.

Alegent Health is among a nationwide group of hospitals participating in the Hospital Quality Alliance, a program managed by the Centers for Medicare and Medicaid Services (CMS) to assess quality. Hospitals are currently required to submit data on 25 indicators that focus on clinical processes, known as Core Measures. Several additional clinical process indicators have been defined by CMS but are not yet required for public reporting.

However, as part of Alegent Health's pledge to provide the highest quality of care, we are voluntarily reporting these five indicators. The Alegent Health Quality Report displays data regarding the performance of all Alegent Health Omaha/Council Bluffs metro-area hospitals: Bergan Mercy, Immanuel, Lakeside, Midlands and Mercy/Council Bluffs. (Exhibit 1)

Out of the 30 reported indicators, 21 show how often hospitals provide recommended care known to get the best results for most patients being treated for heart attack (AMI),

heart failure (HF) and pneumonia (PN). Recently, Alegent Health adopted 9 additional quality factors developed by the Surgical Care Improvement Project (SCIP). SCIP is a national partnership of organizations committed to improving the safety of surgical care through the reduction of postoperative complications in the areas of infection, blood clots and heart complications.

Alegent Health Mercy Hospital

Alegent Health Mercy Hospital is southwest Iowa's largest full-service hospital dedicated to the healthcare needs of the more than 200,000 people living in the region. Mercy Hospital has 284 beds, 288 physicians on active staff, 156 full-time RNs and 576 full-time employees.

In 2005, Mercy Hospital earned Magnet status—evidence of our focus on high-quality, patient centered care. Out of 6,000 hospitals nationwide, Mercy Hospital ranks in the top three percent to receive this prestigious distinction.

In early 2007, demonstrating its leadership in providing quality cardiovascular care in the region, Mercy Hospital became the first hospital from Lincoln, NE to Des Moines, Iowa to receive accreditation by the Society of Chest Pain Centers. Providing further proof of the quality of care patients can expect to receive, the Iowa Foundation for Medical Care in 2007 ranked Mercy Hospital number one out of 34 hospitals and health systems in the State of Iowa in the Core Measure initiative for heart failure, Acute MI and pneumonia. Additionally, Mercy Hospital achieved top performer status in the CMS, Premier Inc. pay-for-performance project ranking in the top 20 percent in the country for heart failure, pneumonia and hip and knee replacement.

Mercy Hospital in FY 2007 had 7,930 admissions: 2251 for behavioral health and 5679 for acute medical/surgical services. Over 30,000 patients were cared for in the emergency department in 2007. Almost 15% of gross revenue paid came from Medicaid in FY 2006 well above the average of 9.5% for all urban hospitals in Iowa.

Mercy Hospital Commitment to Quality

For Mercy Hospital there was no magic or mystery to successfully realizing our commitment to quality healthcare. Alegent Health as a system publicly committed to world class quality in 2003 when achieving core measure excellence was deemed a priority by: Alegent Board of Directors, Physician Leadership Council, CEO, Hospital Administration, Department Directors, and point of care staff. This journey has been buoyed by a culture committed to quality; meaningful collaboration between professionals and leadership focused on providing key resources and support. Each year has witnessed significant gains and most importantly, improved patient care.

From its genesis, the commitment rested on the belief by leadership that our healthcare professionals want to do a good job. They want to excel in providing quality healthcare to their patients. In order for that desire to be realized, three needs were identified: a need for tools, a need for data and a need for support. The tools included literature to support projects/outcomes and best practice guidelines. The data needed to be accurate, timely and reliable with a focus on "real time" data results. And, support was

multifaceted in that it needed to be technological; administrative, inclusive of physicians and process improvement staff.

Early challenges centered on transforming an individual approach and hardwiring it into a system's approach. Inconsistencies had to be met with clear expectations. Variability in orders, tools and education was diminished with the introduction of standards. Where there was insufficient support for processes, resources were deployed. And there was a system wide education program instigated to give each hospital facility and its staff a sense of the significance of our commitment to quality.

Most importantly, a culture check was performed at each campus. Three questions were asked: "Do we have the nuts and bolts of excellence?" "How do we achieve excellence?" and "Do we have the leadership support for process change?" Once these questions were candidly addressed, then success was achieved through awareness, interventions and education.

Employees were made aware of the desired outcomes/standards; and how meeting them would improve patient care. Materials were created to help maintain a buzz or energy around a collaborative effort of providing quality care. Staff members were educated with posters and charts as well as tools such as memory joggers and core measure notebooks. This was a dynamic process where success stories through the patient's eyes were shared; new research communicated and everyday conversations were sprinkled with the concepts of evidence-based medicine and best practices.

Interventions included computer based training modules and recognition opportunities. At each stage of the patient care plan, members were asked if this was a core measure and what was the status for indicators, documentation and education.

Education surrounding the core measures reached everyone: current staff, new hires and temporary staff. This is arguably the most dynamic component of all of our processes as it depends on rapid data analysis and responding to change when needed. It centers on critical one-on-one meetings where a variance has occurred for all staff. With the publication of data regularly and the analysis of data through team interaction on a weekly basis the culture reflected our commitment to core measures excellence.

Our process improvement based on a desire to hardwire our system was formulated on some basic tools. We developed and used extensively stickers, checklists, standard orders, core measure pens; nursing quick reference pocket cards and smoking information was added to all discharge instructions. We also used unit based clinical pharmacists.

Perhaps one of the most intriguing challenges on our journey was how to meaningfully engage our already dedicated physicians? We knew they wanted to do their best for the patient. Therefore, administration had to be clear that we weren't trying to "make our numbers look good" but rather it was about instituting excellent evidence-based patient care and reducing mortality and morbidity. We found our physicians to be driven by information and facts, data and transparency, and, above all, ease of use so that patient care would not be unintentionally diminished.

We sought buy-in from campus physician leaders and key admitting physicians. Above all we proceeded with a team approach. In this way we were able to use standard admission orders and standard discharge orders. Both were user friendly and based on evidence-based care. The physicians could individualize the admission orders and were involved in creating order sets.

Most important to engaging physicians is our communication plan. Concurrently, daily communication occurs between physicians, care managers, quality improvement staff and front-line nursing staff, both direct face-face communication and written communication (which is not part of the medical record). On a retroactive basis, communication occurs to discuss core measures outcomes; departmental meetings, medical staff meetings and can include postings in the medical staff lounge. And where there are misses or near misses, there is a one-on-one meeting with the physician.

Rural Hospitals Join the Quality Initiative

While we take this opportunity to review gains made and lessons learned it is important to note that our rural hospitals have also joined our system's initiative. This past year, our four rural hospitals dedicated staff and implemented similar programs that our metropolitan hospitals had begun. With their participation, processes at both metro and rural hospitals are improved because of the interchange of ideas and experiences. Where a rural hospital may not have access to particular resources, processes are developed to specifically address patient needs. Also, hospital staff roles are enhanced through education and teamwork to extend the limited resources a rural hospital may face. While there may be resource limitations, our rural hospitals have not lagged in meeting core measure norms.

In conclusion, Alegent Health began this initiative to improve patient care. We believed and continue to believe that our healthcare professionals not only want to provide quality healthcare but can and will continue to do so. On a personal note, I continue to remain in awe of our staff who are dedicated to continually raise the bar. Their job is made easier when the right tools and support are provided to them. In this way, we believe that value based purchasing should focus singularly on improving healthcare. Dedicating the staff and processes to improving healthcare comes at a cost, however. Therefore we believe if financial incentives are used, they should meaningfully reflect the attendant costs.

Respectfully submitted,

Marie Knedler

Marie Knedler
COO and VP
Alegent Health Mercy Hospital

Exhibit 1

Alegent 30 Quality Report
January – November 2007

Indicates how often Alegent Health provided recommended care known to get the best results for most patients being treated for heart attack, heart failure, and pneumonia, and how often care was provided that is known to reduce complications in surgical patients.