Army Medical Department Changes to Improve Healthcare Outcomes

DoD Task Force on the Future of Military Healthcare
11 July 2007

Paul R. Cordts, COL, MC
Wellness, Disease Management, Prevention Education, and Associated Incentives

Why not “How AMEDD Hospitals...”

By DOUGLAS WALLER

Recently, hospitals can easily dream of the future, but they do not practice today. Outside an elderly patient’s room, the attending physician gathers his residents around a wireless laptop propped on a coffee cart. Staff accesses the patient’s entire medical history—a desk of paper in most private hospitals. And instead of tucking it into the middle of a table, the physician combines it on his computer screen. While staff is seeing the patient, a resident types a request for pain medication, then presses the next button. Seconds later, the printer in the hands pharmacy prints out the order. The drugstore staffs a plastic bag of pills into what looks like a tiny space capsule, then closes it up to the world in a vacuum tube. All the time Ferrell wheeled away from the computer, a nurse walked up with the drugs.

In a big-name institution like the Mayo Clinic, it’s not unusual. For example, Ferrell, 31, a specialist in internal medicine, works at the Veteran’s Affairs hospital in Washington, where the vets who come for the cutting edge of medicine are treated poorly.

If you’re surprised, that’s understandable. Until the early 1990s, care at VA hospitals was so bad that Congress considered shutting down the entire system and phasing VA’s 1,300 veterans’ hospitals at private facilities. Today it’s a very different story. The VA runs the largest integrated health-care system in the county, with more than 1,400 hospitals, clinics and nursing homes, 430,000 doctors and 65,000 nurses. And by a number of measures, the government-managed health care program—socialized medicine on a small scale—is beating the marketplace. For one thing, the average VA hospital lost 10 percent higher than private hospitals at the University of Michigan’s American Customer Satisfaction Index, based on patient surveys of the quality of care received. The VA scored 86, not 99 percent, in private institutions.

On the other hand, because advances in body and brain and field medicine have enabled soldiers to survive battlefield injuries that in earlier conflicts meant death, many of the new patients are arriving at VA hospitals with severe wounds. In response, the VA has set up four polytrauma centers around the country. David Belford, a former Army captain who had his right arm and leg amputated in Iraq, says negotiating the bureaucracy to get treatment for all his medical needs has been frustrating at times. He had to wait eight months for an appointment at the Washington hospital to get his teeth cleaned. Even so, he says it’s not as bad as he thought it would be.

The needs of the VA’s system are changing. Back in 1984, when Bill Clinton appointed Kenneth Kizer, a heart-changing doctor and former Navy admiral, as the VA’s undersecretary for health, Kizer decentralized the VA’s cumbersome health bureaucracy and held regional managers more accountable. Patient records were transferred to a systemwide computer network, which made it easier to simplify private hospitals. When a veteran is treated, the doctor has the veteran’s complete medical history on a laptop. In the private sector, 20% of all lab tests are needlessly repeated because the doctor doesn’t have the corresponding results and has to pay for the test twice.

Another innovation at the VA was a bar-code system, as in the supermarket, for prescriptions—system used in fewer than 5% of private hospitals. With a hand-held laser reader, the nurse scans the bar code on a patient’s wristband, then the drug on the bottle of pills. If the pill doesn’t match the prescription, the drug is rejected into the computer, the laptop alerts the nurse. The Institute of Medicine estimates that 1.5 million patients receive the wrong drug each year. For example, it found that computer records and bar-code scanners have virtually eliminated those problems in VA hospitals.

Private hospitals, which make their money treating people who come to them sick, don’t do as well. Congress has no plans to enlarge the scope of veterans’ health-care much less consider it a model for, say, a government-run New York health-care system. But it’s becoming more and more “ideologically” courageous to support it with a model for a national health-care system. And, for example, the VA’s system can fulfill its promise to provide quality care because it’s been affordable to veterans since 1958. Veterans’ groups understandably want the health-care system expanded to accommodate veterans with higher incomes and veterans who are not eligible veterans. And the VA has expanded its service to new veterans and to service-related injuries or illnesses to those who have incomes below the poverty line.

But conservatives fear such an arrangement would be a Trojan horse, setting up an even larger national health-care program. And taking more money from the private sector. Congress has no plans to enlarge the scope of veterans’ health-care much less consider it a model for, say, a government-run New York health-care system. But it’s becoming more and more “ideologically” courageous to support it with a national health-care system. And, for example, the VA’s system can fulfill its promise to provide quality care because it’s been affordable to veterans since 1958. Veterans’ groups understandably want the health-care system expanded to accommodate veterans with higher incomes and veterans who are not eligible veterans. And the VA has expanded its service to new veterans and to service-related injuries or illnesses to those who have incomes below the poverty line.

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Wellness, Disease Management, Prevention Education, and Associated Incentives

Agenda

- IHI Goals
- Pneumococcal Vaccine Initiative
- HEDIS Measure Initiative
- Medical Coding Accuracy
- Medication Reconciliation
- Prevention of VAP
- Provider Scorecard
- Patient Satisfaction

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IHI 100,000 Lives Saved Campaign Interventions

- Deploy Rapid Response Teams to patients at risk for CP arrest
- Deliver reliable, evidence-based care for acute myocardial infarction
- Prevent adverse drug events through drug reconciliation
- Prevent central line infections
- Prevent surgical site infections
- Prevent ventilator-associated pneumonia
IHI 5 Million Harm Events Prevented Campaign (The “Planks”)

• Prevent Pressure Ulcers

• Prevent MRSA Infections

• Prevent Harm from High Alert Medications

• Reduce Surgical Complications – Adopt “SCIP”

• Deliver Reliable, Evidence-Based Care for CHF

• Get Boards on Board
Clinical Policies

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<td>AMEDD HEDIS Performance Goals</td>
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<td>Medical Coding Improvement</td>
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<td>4.</td>
<td>Standardization of UCAPERS and MEPRS Reporting</td>
<td>Feb 07</td>
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<td>5.</td>
<td>Outpatient Medication Reconciliation Using AHLTA</td>
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<td>6.</td>
<td>Prevention of Ventilator-Associated Pneumonia (VAP)</td>
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Pneumococcal Vaccine Initiative

To increase the percentage of beneficiaries 65 years of age and older with a Pneumovax immunization, MTFs worked to vaccinate 65% of their eligible population by June 2007 and will work to vaccinate 95% of their eligible population by January 2008.
Pneumococcal Vaccinations

**Background:**
- Pneumococcal disease is the sixth leading cause of death in the US
- Pneumovax® is the most cost effective prevention currently available
- The Pneumovax® campaign has the potential to save $500 per vaccine given

**Goals:**
- Increase immunizations among beneficiaries age 65 and over
- Vaccination Rate Targets:
  - 45% by January 2007
  - 65% by June 2007
  - 95% by January 2008
- MTFs that reach these goals receive $5 per vaccinated beneficiary age 65 and over
Bacterial Pneumonia Admission Rates per 1000
HEDIS Measures

The Health Plan Employer Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The goal is for each MTF in AMEDD to exceed the 90th percentile on publicly reported HEDIS performance quality measures NLT 1 Oct 07.
HEDIS Measures

**Background**
- MEDCOM and MTFs use HEDIS results to see where they need to focus their improvement efforts
- MEDCOM adopted 7 HEDIS measures:
  - Percent of eligible population with Mammograms
  - Percent of eligible population with Asthma on Long Term Controller Medications
  - Percent of eligible population with Diabetes with AIC Testing
  - Percent of eligible population with Diabetes with AIC <9
  - Percent of eligible population with Diabetes with LDL <100
  - Percent of eligible population with Cervical Screening
  - Percent of eligible population with Colo-Rectal Exam

**Goals**
- Each MTF should be in the 90th percentile of publicly reported HEDIS quality measures NLT 1 October 2007

**Incentive System**
- MTFs that reach the 50th or 90th percentiles on any measure are rewarded quarterly under PBAM
Army Performance-Based Adjustment Model (PBAM)

Financial adjustment to MTF Prospective Payment System based reimbursement for:

– Financial Ambulatory Productivity (outpatient productivity)
– Compliance with Length of Stay Standards (inpatient utilization management)
– Compliance with Evidence-Based Clinical Practice (clinical quality)
## Command Management System

### Evidence-based Healthcare

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TOTAL $847,893
Wellness, Disease Management, Prevention Education, and Associated Incentives

AMEDD CODING COMPLIANCE

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Medication Reconciliation

• Initial baseline data shows the percent of encounters completed in AHLTA in which the MedRec term was checked
• Based upon meeting with MEDCOM Patient Safety:
  – AHLTA PM will see if data pull can be limited to visits in which a medication change occurred
  – OTSG Patient Safety will determine if a patient who is not leaving the direct care system is required to receive a medication list
• Work ongoing to provide this as a local MTF report
Wellness, Disease Management, Prevention Education, and Associated Incentives

Percent of MedRec Term Use by MTF*

* Based on 40,000 "Kept" encounters on 7 May 2007. "Ambulatory Care" clinics only; no Telcons.
Ventilator Associated Pneumonia (One MTF)
Ventilator Associated Pneumonia (One MTF)

Critical Care VAP Rate

#VAP/1000 vent days

1Qtr 2Qtr 3Qtr 4Qtr 1Qtr04 2Qtr 3Qtr 4Qtr 1Qtr 2Qtr 3Qtr 4Qtr 1Qtr06 2Qtr 3QTR 4thQtr
Provider Scorecard

The Provider Scorecard was created to allow personnel to quickly gauge the performance of a provider, clinic or MTF including satisfaction, productivity, data quality and clinical quality metrics in a snapshot format.
For family practice, Clinical Quality is currently measured by diabetics with A1C readings $\leq 9$. Scores are available for the last month, 3 months and 12 months. Other measures are forthcoming for other specialties.

The scatter plot shows this provider’s clinical quality measure compared to other providers at the same location.

The line graphs show the provider, clinic, MTF and RMC’s clinical quality scores over a rolling 12 month period.

Clinical Quality Source: Pop Health Portal
METRIC 2: Customer-Reported Satisfaction Levels as reported by APLSS

Provider Scorecard

Satisfaction scores come from 2 questions on the APLSS Survey: helped listened to patient and patient. The scorecard value reflects the percentage of respondents who checked the top two boxes on the survey in the last month, 3 months and 12 months.

The scatter plot shows this provider’s satisfaction measures compared to other providers at the same location.

The line graphs show the provider, clinic, MTF and RMC’s satisfaction scores over a rolling 12 month period.

Customer Satisfaction Source: APLSS
METRIC 3: Data Quality as measured by records completed within 72 hrs.

 Providers are scored on data quality by the percentage of records they complete within 72 hours of an encounter.

The scatter plot shows this provider's data quality measures compared to other providers at the same location.

The line graphs show the provider, clinic, MTF and RMC's satisfaction scores over a rolling 12 month period.

Data Quality Source: PASBA
Provider Scorecard

METRIC 4: Productivity

Providers are scored on the number of RVUs they generate during available clinic time.

The scatter plot shows this provider’s productivity compared to other providers at the same location.

The line graphs show the provider, clinic, MTF and RMC’s productivity over a rolling 12 month period.

Productivity Sources: M2, UCAPERS, DMHRS, DMHRSi
Patient Satisfaction with Clinic Visit

“7s” – Completely Satisfied (Delight)

Key Points
- Completely satisfied members: 37% FY05; 44% FY06
- Noticeable increase from FY05 to FY06

Percent represents only those members giving a top score of “7” on 1-7 scale
The Eight-Stage Process of Creating Major Change*

1. Establishing A Sense of Urgency

2. Creating the Guiding Coalition

3. Developing A Vision and Strategy

4. Communicating The Change Vision

5. Empowering Broad-Based Action

6. Generating Short-Term Wins

7. Consolidating Gains and Producing More Change

8. Anchoring New Approaches in the Culture

Wellness, Disease Management, Prevention Education, and Associated Incentives

Developing Metrics and Assigning Accountability
Health Systems Levels: Micro-, Meso-, and Macrosystems

Microsystem
Patient, Provider, and Clinic Accountability

Mesosystem
Service, Department, MTF, RMC Accountability

Macrosystem
MEDCOM, TMA and HA Accountability

Point of Care
Decision Support

Clinical Evidence
Base

Intellectual
Environment

Care Recipient

AHLTA

ED, Clinics, ICUs, ORs, Ancillary, etc

Provider/Clinic

RMC, MEDCEN, MEDDAC, etc.

Team Performance Measures

Patient-centric Care

Incentives

OTSG/MEDCOM

Resource Allocation

Clinical Quality Metrics

Market/Regulatory Environment

Developing Metrics and Assigning Accountability
Organization of Excellence

• How do we manage the data at hand?
  - Data invisible to leadership (stovepipe discussions)
  - Monitoring natural history or random variation
  - Presenting actionable data at every level
  - Willingness to stop doing things (e.g., DQMCP)

• How do we reward desired behaviors?
  - Reward desired behaviors early and repetitively and celebrate along the way

• Transition to profiling the healthcare system, not simply the individual

• “Delight” vs. satisfaction
Actions Must We Take

• Decide what is important
• Align processes to achieve it - Demand excellence
• Write policy which aligns with metrics, establish an initial best-practice, and state the benefit of doing it this way
• Make data available and display eloquently
• Share Lessons Learned
Actions Underway

• Consolidation of stovepipe systems and their databases:
  – Metrics as by-product of healthcare delivery
  – Improved use of “human capital”
  – Use of enterprise tools

• Redesign the healthcare module (staffing, space, etc.) based upon current deployment of global EHR aligned around outcome improvement
“Redefining Healthcare”*

• “The only way to truly reform healthcare is to reform the nature of competition.”

• “Mandatory measurement and reporting of results is perhaps the single most important step in reforming the healthcare system.”

• “Competition on results . . . .”

• “Good quality is less costly” because of more accurate diagnoses, fewer treatment errors, lower complication rates, faster recovery, less invasive treatment, etc.”

Appendix

Nutrition Care Education and Foodservice Initiatives
Making it Fresh Objectives

- To use the dining experience to increase nutrition knowledge for all customers – knowledge based on current scientific evidence of nutrition and health
- To provide freshly prepared wholesome foods preferred by customers and patients
- Decrease utility costs by 10-20%
- Increase surcharge and customer traffic by ~ 65-75%
- To improve the health and performance for Soldiers, civilian workforce, hospital patients in medical treatment facilities and visitors
- To partner the concept with:
  - Ultimate Warrior Website
  - Defense Commissary Agency
  - Army Center of Excellence for Subsistence (Quartermaster)
Wellness, Disease Management, Prevention Education, and Associated Incentives

**GO FOR GREEN**

_Eat like an Athlete  
Train like a Pro  
Perform like a Champion_

**High Performance Foods**

- Premium fuel for the Soldier Athlete
  - Fresh and flavorful
  - Nutrient dense
- *Go for Green:* Choose frequently

**Moderate Performance Foods**

- Higher in calories
- Lower in vitamins and minerals
- Use Caution: Select less frequently

**Performance Limiting Foods**

- Highest in calories
- Low in vitamins and minerals
- May increase body fat
- Warning: Limit intake
The Ultimate Warrior Website on AKO

HOOAH Bodies

and

Weigh to Stay
OUTCOMES of Weight To Stay Pilot Project

Explicit Cost Savings:

$950.00 per participant. (Travel and duty time)

Potential cost savings:

$13.3 M for all flagged AD Soldiers.

$80.5 M per year for training costs savings from attrition

Implicit Cost Savings:

Health benefits of 85.5% successfully losing weight.

Average weight loss over 20 days:

7.15lb = USNG

5.62lb = AD

5.0 lb = USAR

4.5 lb = AGR
OUTCOMES for Weight to Stay Pilot Project

Satisfaction:
Extremely informative = 93%
Extremely focused on their needs = 93%
Best way to train = 97%
  Ideal for remote sites
  Safer for deployed Soldiers
  Anonymous