

Dashboard Benchmark Evaluation

Student 2

2018

Dashboard Benchmark Evaluation

The Affordable Care Act (ACA) played a role transforming health care with measuring performance with quality of care and safety in exchanged from quality based care for reimbursement in healthcare (Lamb, 2013). Health care organizations now have to create dashboards and benchmarks to measure and set standards of care (National Committee for Quality Assurance (NCQA), 2016). Dashboards allow leaders to examine injury and chronic disease care process measurements (MN Department of Health, 2014). Healthcare Effectiveness Data and Information Set (HEDIS) evaluation is a tool utilized by states and federal government as a dashboard of quality performance measurements (Agency for Healthcare Research and Quality (AHRQ), 2013). Dashboards provides a report that collect data for performance measures but can also track quality improvements as changes in practice occurs (AHRQ, 2013). Comparing quality performance is considered benchmarking that encourages healthcare providers and organizations to compare themselves to like providers or organizations for best practices (The Benchmarking Exchange, n.d.). Hopefully the other provider or organization that may have higher quality scores would share the processes they have initiated to assist comparing practice. With that being said, this report will examine the population of Shakopee, MN chronic condition of diabetes and Mercy Medical Center CEO dashboards. We will evaluate the dashboards, analyze the challenges each are facing, look at how each areas are underperforming, and advocating for improvement. First let's examine the two dashboards.

Dashboard Evaluations

Before evaluating dashboards, it is crucial to understand the population being served. We understand Shakopee, MN has a population of 36,192, with 76% of population is white, 10%

Asian, 7% Hispanic and 4% African American (Capella Education Company, n.d.). We need this data to be able to compare and explain where issues may arise or have effects on particular populations. The evaluation shows there has been an increase in white, females within the 45-64 age range that are new patients with diabetes (Capella Education Company, n.d.). Since 76% of the population is white, the data reflects the increase within the white population due to the majority within the city. There was an increase of patients obtaining HgbA1c levels measured, foot exams and eye exams performed in the last quarter of 2015 and beginning quarter of 2016 (Capella Education Company, n.d.). The increase of HgbA1c levels measured, eye exams and foot exams performed can be indicative or influenced by initiatives to improve quality for collecting data of new diabetic patients for the HEDIS evaluation (Agency for Healthcare Research and Quality (AHRQ), 2013). Comprehensive diabetes management of care is one area the HEDIS tool evaluates (NCQA, 2016). The Centers for Medicare and Medicaid Services (CMS), (2017), dashboard data provides the national average for diabetes management of 26.55% compared to MN 20.42%. According to NCQA, (2017), for providers to provide quality comprehensive diabetic care for patients between the ages of 18-75, they have to provide the following: an “A1C of less than 8%, retinal eye exam performed, a blood pressure less than 140/90 and medical attention for neuropathy” (foot exam by podiatrist) (NCQA, 2017, para 1). We only have limited data to compare to national data, or even city to state. The second dashboard we will examine is the Mercy Medical Center CEO dashboard.

The Mercy Medical Center provides acute care services to the Shakopee, MN population (Capella Education, n.d.). The Mercy Medical Center hospital CEO dashboard provides readmission rates compared to national average, errors or injuries occurring per unit and nurse

staffing in comparison to census and Nursing Full Time Employees (FTE) (Capella Education, n.d.). The re-admission rate of Heart Failure (HR) is 40% for facility, which is higher than the national benchmark of 37% compared to a decrease in chronic obstructive pulmonary disease (COPD) readmissions at 31% compared to 34% national average and steady rate of quality measures on pneumonia readmissions sitting at 29% compared to 29% national average (Capella Education Company, n.d.). The MN Department of Health (DOH) dashboard shows the number of heart disease hospitalizations was stable at 45,678 and that adults with controlled high blood pressure was currently stable at 76. 2% but no national data to compare (MN Department of Health, 2014). CMS national dashboard illustrates the MN state prevalence of HF is at 10.60% and national average of 13. 46% (CMS, 2017). The CEO dashboard of HF at 40% is extremely higher than the national average of 13.46%. The data of amount of patient errors can be related to the number of FTE nurse staffing in relation to patient census and can play a role in discharging HF patients. Since some units show improved quality and safety, the CEO needs to address how the fall, pressure ulcer, medication and documentation errors are currently being addressed by those unit managers to assist the other units and investigate how patient safety issues and re-admissions correlate with Registered Nurse (RN) FTE rate per day. Let's look at the challenges.

Challenges

There are many challenges that could be effecting the Shakopee, MN population and Mercy Medical Center. The limited amount of data provided does not provide the whole picture for a better evaluation, but the numbers of foot, eye and HgbA1c labs performed, re-admission data for COPD, pneumonia and HF, errors and injuries per unit and nurse staffing was a good start. We can only assume that the lack of staffing, education or care coordination can attribute to both

the CEO dash board or ability to continue diabetes care for MN DOH dashboard effects the accuracy of this evaluation. One big challenge is the patient's acceptance to diabetic or HF care, complying with medical instructions and continuing follow up care to ensure needed exams can be performed in set time frames to collect accurate data (NCQA, 2017). All providers need to encourage the patient and family to continue the management of diabetes and HF. We would need more detail data instead of assuming that there is a correlation between staffing and adverse events for the CEO dashboard. According to Cho, Chin, Kim & Hong, (2016), poor work environment and larger number of patients to nurse ratio has shown an increase in adverse events like pressure ulcers, falls, and medication errors to occur. The health care team needs to come together to discuss quality and safety issues that may not have be brought to leadership's attention. Let's look at underperformance.

Evaluates Benchmark Underperformance

The data provided in the CEO dashboard indicates a need for more work on HF education during discharge compared to COPD and pneumonia. The HF data also shows a need to investigate the facilities practices when discharging HF patients and compare practices with other facilities to improve HF readmissions rate. Half of re-admissions of HF are preventable and related to the following: "inadequate teaching, nonadherence, or inadequate post discharge follow-up" (White & Hill, 2014, p. 1). CMS punishes providers and facilities if they have excessive readmissions due to not meeting HF requirements by reducing Medicare payments (CMS, 2018). We do not know how many patients within the community has continued access to care to manage diabetes and HF, or if providers provide programs for prevention of chronic diseases with health and wellness promotion or just lack of patient willingness to participate, but

all of the above can be related to the decrease in diabetic evaluation in quarter 2-4 of 2016 and increase in HF readmissions (Capella Education Company, n.d.). Now let's explore how to advocate and improve quality of care and improve dashboards rates.

Advocates Quality Improvements

According to the Minnesota (MN) Department of Health, (n.d.), MN offers a Diabetes Self-Management Education and Support (DSMES) program for the population in MN to manage diabetes as an initiative to improve the quality of care and health of the diabetic population. CMS provides guidelines that all HF patients need to have patient-centered coordinated care that follows the core guidelines that includes: "HF self-care and symptom management education, a 7 day follow up, Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD), controlling blood pressure measures, and anticoagulation status" (CMS, 2018, para 2). Mercy Medical Center just has to incorporate the guidelines into practice while discharging HF patients (CMS, 2018). Neil, (2015), discusses the importance for health care providers and facilities to meet the standards of practice that is based on evidence-base practice, providing quality and safe care, and recognized by accrediting bodies for improved quality and safety practices occurring.

For both the general population and patients of Mercy Medical Center, health care providers need to drive the importance of health care promotion in self-care of their chronic diseases to assist with improving the quality and safety of care (Lamb, 2013). The population needs to be aware of how to manage their diseases and voice concerns when visiting health care facilities if they feel the care is not safe. The population can only voice their concern with

confidence once they are educated by all health care providers. Quality and safety can only improve when everyone is on board with needed changes. Dashboards and benchmarks provide the buy-in for those changes (AHRQ, 2013).

References

- Agency for Healthcare Research and Quality (AHRQ). (2013). Practice facilitation handbook: Module 7: Measuring and benchmarking clinical performance. Retrieved from: <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod7.html>
- Capella Education Company (n.d.). Vila Health: Dashboard and health care benchmark evaluation. Retrieved from: <https://media.capella.edu/CourseMedia/NHS6004/DashboardandHealthCareBenchmarkEvaluation/transcript.html>
- Centers for Medicare and Medicaid Services (CMS). (2018). Hospital readmissions reduction program (HRRP). Retrieved from: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>
- Centers for Medicare and Medicaid Services (CMS). (2017). Medicare chronic conditions dashboard: state Minnesota: Comparison by geographic areas of conditions: 2015. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/chronic-conditions-state/cc_state_dashboard.html
- Cho, E., Chin, D. L., Kim, S., & Hong, O. (2016). The relationships of nurse staffing level and work environment with patient adverse events. *Journal of Nursing Scholarship*, 48(1), 74-82.
- Lamb, G. (2013). Care Coordination: The game changer- How nursing is revolutionizing Quality of care. Silver Spring, MD: American Nurses Association.

Minnesota (MN) Department of Health. (n.d.). Disease: Diabetes. Retrieved from: <http://www.health.state.mn.us/divs/healthimprovement/health-information/disease/diabetes.html>

Minnesota (MN) Department of Health. (2014). Indicator dashboards: Healthy Minnesota 2020: State chronic disease & injury dashboard. Retrieved from: <http://www.health.state.mn.us/divs/healthimprovement/dashboard2016/index.html>

National Committee for Quality Assurance (NCQA). (2017). Comprehensive diabetes care. Retrieved from: <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2017-table-of-contents/diabetes-care>

National Committee for Quality Assurance (NCQA) (2016). HEDIS & Quality measurement: Performance measurement. Retrieved from: <http://www.ncqa.org/hedis-quality-measurement/performance-measurement>

Neil, H. P. (2015). Legally: What is quality care? Understanding nursing standards. *MEDSURG Nursing*, 24(1) 14–15.

The Benchmarking Exchange. (n.d.). What is benchmarking? Retrieved from <http://www.benchnet.com/wib.htm>

White, S. M., & Hill, A. (2014). A heart failure initiative to reduce the length of stay and readmission rates. *Professional Case Management*, 19(6), 276-284.