Approved by the Intermountain Board
March 29, 2011

2011 CLINICAL BOARD GOALS

WOMEN & NEWBORNS CLINICAL PROGRAM

Overview & Opportunity: One of the most serious problems facing pregnant women in the United States is venous thrombosis and embolism (VTE). The Joint Commission has issued a sentinel alert in 2010 that underscores the importance of VTE as a cause of major maternal morbidity and mortality. VTE is the single leading cause of maternal death in developed countries, surpassing the rate of death by hemorrhage, infection and hypertensive disorders.

2011 Goal for the Women and Newborns Clinical Program

Improve compliance with mechanical VTE prophylaxis in antepartum and cesarean section patients, groups at particularly high risk for VTE. Current system compliance with accepted prophylactic practices is 55.5% and was determined using electronic documentation and direct observation in Labor and Delivery (L&D) and postpartum units.

Entry Goal: 90% compliance
Target Goal: 92% compliance
Stretch Goal: 94% compliance

Clinical Challenges to Meet the Goal: L&D has never addressed VTE prophylaxis in high-risk pregnant women on bed rest and as a result the challenge in meeting this goal is the significant educational effort and culture change that will need to take place. Both L&D and Mother/Baby units have done VTE prophylaxis in post cesarean section patients, however, RN experts have noted challenges and inconsistencies with charting and actual compliance with mechanical prophylaxis.

Methodology: This initiative will include all Intermountain Healthcare birthing sites with at least 10 high-risk antepartum or Cesarean delivery patients per month. Candidate antepartum patients will be identified at the time of admission in the electronic medical record. Cesarean delivery patients will be identified in L&D at the time of the decision to perform the surgery. We will perform 100% audits of the electronic documentation of candidate patients and periodic direct observational documentation of the appropriate use of mechanical VTE prophylaxis on the maternity units and in L&D.

Measurement Time Period: Third Quarter 2011

CONFIDENTIAL: This information is for an Intermountain Healthcare Peer or Care Review Committee to evaluate and improve health care. See Utah Code 26 25 1, et seq., or Idaho Code 39 1392, et seq.

CARDIOVASCULAR CLINICAL PROGRAM

Overview & Opportunity: The number of patients exposed to ionizing radiation (x-rays) has continued to grow even though we have a more enlightened understanding of the long-term adverse consequences of cumulative radiation. Optimizing the use of x-rays in managing patients should include the information about the patient's historic cumulative radiation exposure. This board goal will both provide this measure and begin to improve the care that utilizes x-rays.

2011 Goal for the Cardiovascular Clinical Program

Working in collaboration with the Intermountain Radiology Program over the next two years, we will address the ionizing radiation delivered only at Intermountain Healthcare facilities. For common major x-ray tests or procedures (CT studies, angiography, nuclear cardiology, and cardiac cath), we will monitor, measure, and report the cumulative radiation for each patient and make the information available and understandable. Along with this information, education will be provided to the patients and caregivers regarding the interpretation of the data, including the limitations of how the cumulative dose is calculated. In addition, to avoid unnecessary radiation exposure we will create appropriate use criteria for: 1) CT pulmonary angiography for possible pulmonary embolus and 2) nuclear stress tests for managing coronary artery disease; thus assessing the risk-benefit to optimize the processes of care and protect patients from unnecessary radiation.

Entry Goal: 40% composite completion
Target Goal: 50% composite completion
Stretch Goal: 60% composite completion

Clinical Challenges to Meet the Goal: Currently, there are no healthcare systems that are capturing cumulative radiation dose. Intermountain Healthcare will be leading the nation with this effort by developing the methods and content to educate clinicians and patients.

Methodology: A two-year project plan will be developed describing eight milestones needed to attain the Board Goal. The milestones are: 1) based on the x-ray test or procedure, assure the devices can measure radiation dose or if not, systematically determine an estimated dose that can be used, 2) develop a process to consolidate existing x-ray test and procedure source data into the radiology EDW schema, 3) begin development of a simple software application to collect device measured radiation doses, 4) develop reporting strategies and mechanisms, 5) develop materials to educate patient on cumulative radiation dose, 6) develop materials to educate physicians on cumulative radiation dose and how to use the information during decision making,7) add cumulative radiation dose to MyHealth for SelectHealth patients, and 8) create appropriate use criteria for above processes. The details of the project plan will contain deliverables necessary to meet each milestone with each milestone having at least 10% completion. Each milestone will be managed. At the end of the Third Quarter 2011, the median of the percentage of the deliverables completed for the milestones will be calculated as the composite percentage of completion for the overall project.

Measurement Time Period: Third Quarter 2011

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PRIMARY CARE CLINICAL PROGRAM

Overview & Opportunity: Glyco-hemoglobin (HbA1c) is a laboratory blood test that indicates a patient's average blood sugar over a three-month time period. It is the best measure of diabetes control. Studies show that a glyco-hemoglobin level below 7 (HbA1C<7) prevents complications from diabetes (heart disease, kidney disease, eye disease, and circulation and pain in the feet and legs). Our goal is to improve diabetes control in patients who are most severely out of control as indicated by having an HbA1c≥8 for 12 months or longer.

2011 Goal for the Primary Care Clinical Program (PCCP) and SelectHealth

Improve the average HbA1c for SelectHealth patients age 18 and over with diabetes who have had a glycohemoglobin ≥ 8.0 for at least 12 months on Oct 1, 2010 from 9.76% to 9.32%.

Entry Goal: 9.41%
Target Goal: 9.32%
Stretch Goal: 9.23%

Clinical Challenges to Meet the Goal: The challenge in achieving this goal is that there are many complex reasons for uncontrolled diabetes (as shown by HbA1C > 8 for 12 months or longer). These include inadequate medical care and patient failure to follow the medical care plan due to financial challenges, life stressors, additional co-morbidities (other chronic illnesses), mental health issues, and socioeconomic issues.

Methodology: Patients will be identified from the diabetes data mart on October 1, 2010. The diabetes data mart includes data from SelectHealth claims, the Clinical Data Repository (CDR), SelectHealth pharmacy data, IDX, and Mysis (laboratory) data bases. It is updated quarterly and housed within the EDW and maintained by EDW staff and PCCP staff. The average HbA1c of these patients will be tracked monthly and the final results will be available October 15, 2011.

Measurement Time Period: October 2010 - October 2011

SURGICAL SERVICES CLINICAL PROGRAM

Overview & Opportunity: Intermountain's red blood cell transfusion threshold is higher than expert recommendations. The risks associated with transfusions are underestimated and not well understood. A meta-analysis of nine clinical trials showed that implementing a restrictive red cell transfusion practice decreases the probability of red cell transfusion by 42%. A restrictive transfusion policy includes educating ordering physicians about appropriate transfusion thresholds and transfusion risks, as well as requiring ordering physicians to provide a transfusion indication. Over the past two years, our Quality Development Team has been working with three pilot sites (LDS, Intermountain Medical Center, and Dixie) in developing a new process to capture red blood cell transfusion indications. Currently, the pilot sites are electronically capturing the transfusion indicator 0% of the time. We have redesigned our information systems to collect the physician transfusion indication.

2011 Goal for the Surgical Services Clinical Program

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Implement an automated system that captures the indication for transfusion to prepare the system for a 2012 reduction in RBC usage.

Percent of electively transfused, cross-matched blood with a transfusion indicator.

Entry Goal: 75%
Target Goal: 85%
Stretch Goal: *95%*

Clinical Challenges to Meet the Goal: The newly redesigned blood ordering, requesting, and documentation system in HELP will be implemented in the three pilot facilities. This change in practice will be completely new in some areas (ED, OR) with minor changes in others (Medical/Surgical Units). This new electronic process will replace the existing paper process and manual data abstraction required for compliance certification. Significant work will be required to develop facility reports to meet compliance certification for the pilot sites. Wireless bar code scanners are a necessary piece of capital for successful implementation for this goal. This 2011 goal will provide a solid basis by which to expand the anticipated positive outcomes to the rest of the system in 2012.

Methodology: The Surgical Services Clinical Program will support facility leadership with education, creation of reports, analysis of data and outcomes reporting.

Measurement Time Period: Third Quarter 2011

PATIENT SAFETY

Overview & Opportunity: Preventing patient falls in hospitals has become a clear national priority. Fall prevention has been a National Patient Safety Goal since 1998. In 2008, the Centers for Medicare and Medicaid Services (CMS) implemented a reimbursement rule that prohibits charging for injuries related to patient falls. The Utah Hospital Association implemented a statewide guideline in 2009 supporting 'not seeking payment' for these injuries for all payer types. Patient falls with significant permanent injury or death are also considered 'Sentinel Events' and are reportable to the state of Utah. National rates range from 1 – 20 falls per 1000 patient days depending on the patient population and facility type. Intermountain Healthcare has made some progress reducing falls from a rate of 6.67 in 2007 to 4.41 in 2010 (rate per 1000 patient days; PCMC not included in calculations), further reduction is considered possible and desirable for this critical patient safety initiative. Work will be done to further standardize interpretation of definitions of fall type and injury in preparation for a more focused goal in 2012.

2011 Goal for Patient Safety

Attain a statistically significant reduction in the inpatient fall rate for the system by the end of the third quarter 2011. The system baseline is 4.41 falls per 1000 patient days (12 months, 2009 Q3 to 2010 Q2). Comparable statistically significant regional targets will by calculated using regional baseline data (2009 Q3-2010 Q2). Goal attainment will be measured by region.

Entry Goal: 4.26 rate/1000 patient days
Target Goal: 4.21 rate/1000 patient days

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Stretch Goal: 4.17 rate/1000 patient days

Clinical Challenges to Meet the Goal: Intermountain Healthcare has an existing system Fall Prevention Team that has researched and implemented a number of tools and processes to reduce falls including a Fall Prevention Protocol, Fall Risk Assessment Tools, Documentation and Falls Alert Tools, and Educational Modules. Regions are accountable to use these processes and tools, evaluate failures and implement appropriate performance improvement initiatives. Literature reviews and root cause analysis demonstrate that fall prevention success includes comprehensive and timely patient assessment, appropriate care plans, and implementation of patient specific prevention strategies.

Methodology:

- The current 'Web Event' reporting system will be utilized to identify patient fall events.
- The fall rate is comprised of inpatient fall events for the numerator and inpatient days for the denominator (Inpatient days derived from the Clinical Data Repository)
- PCMC is not included because their rate is statistically significantly lower than the system rate.

Measurement Time Period: July – September 2011

RURAL FACILITIES

Overview & Opportunity: Preventing medication errors is a focus nationally. The Joint Commission focuses a number of standards on processes to reduce medication errors. Several years ago Intermountain Healthcare created a bar code medication administration (BCMA) program that includes scanning the patient identification band and comparing against the electronic medication administration record profile produced by pharmacy for a given patient. The rural facilities have implemented this program during the last year. One measure of the effective use of this patient safety software is the BCMA override rate. This gives us the percentage of times that a nurse does not use the BCMA feature for some reason. When this occurs, the electronic safety mechanism is lost for that particular medication administration. The nurse is responsible for direct identification and medication checks. Overrides can be unsafe and have resulted in some serious adverse events to patients in our system. The rural facilities BCMA override rate averaged 4.5% for the first six months of 2010, with a range of 3.8% to 8.6% for individual facilities. The system BCMA override rate for the same period is 3.4%.

2011 Goal for Rural Facilities

Attain a statistically and clinically significant reduction in the bar coding medication administration override rate for the rural facilities by the end of third quarter 2011.

Entry Goal: 3.8%
Target Goal: 3.4%
Stretch Goal: 3.0%

Clinical Challenges to Meet the Goal: The rural facilities have limited resources to change and support these new processes. None of our rural hospitals has 24 hour on-site pharmacists. Pharmacy and Nursing leadership support is critical.

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Intermountain Healthcare has a system Bar Code Medication Administration Team that has researched and implemented a number of tools and processes to reduce override rates. Facilities are accountable to use these processes and tools, evaluate failures and implement appropriate performance improvement initiatives at the facility level.

Methodology:

- The Enterprise Bar Code Medication Administration Override report will be used to calculate a rate for each facility.
- The average will be taken from the measurement time period for the region facilities.

Measurement Time Period: July – September 2011

INTERMOUNTAIN HOMECARE

Overview & Opportunity: Traditionally, hospitals have focused on acute care, but in today's world patient care has become increasingly chronic in nature, involving long-term management needs for complex and multiple illnesses. Health care payors, especially the Centers for Medicare and Medicaid (CMS), have established policies and procedures to avoid paying hospitals for readmissions of certain diagnosis. Among others, these include wound care and infection. CMS is also considering bundling payments for hospitals and post acute care providers by 2014. This has shifted the focus for the hospitals, requiring them to rely more on the strength of the continuum partners to manage the patient effectively to avoid unnecessary readmission. Not only we will be able focus on the reduction of readmission rates, we will also be able to analyze the data by patient populations to identify opportunities for care improvement which has implications systemwide.

2011 Goal for Intermountain Homecare

Improve Intermountain Homecare/Home Health's acute care re-hospitalization rates during the certification period which is no greater than 60 days. The current baseline is 13.12% (Third Quarter 2010).

Entry Goal: 12.68%
Target Goal: 12.60%
Stretch Goal: 12.43%

Clinical Challenges to Meet the Goal: The challenge in achieving this goal includes identifying best practices to reduce re-hospitalizations of a variety of diagnoses and to continue to reduce a rate that is already low.

Methodology: Monitor the requirements of acute care re-hospitalization rates monthly, with year-to--date aggregation of the score through McKesson Horizon. Data will be based on actual numbers. Measurements will exclude patients under 18, planned admissions for surgeries or events, observation patients, auto accidents and non-federal payors.

Measurement Time Period: Third Quarter 2011

PRIMARY CHILDREN'S MEDICAL CENTER

Overview & Opportunity: Numerous studies have shown that nosocomial catheter-associated blood stream infections (CA-BSI) are associated with increased risk of mortality and increased length of stay. For the child with cancer, acquisition of a CA-BSI can be particularly dangerous. Because of their immune-compromised state and prolonged need for a central line, these children are at a significantly higher risk for development of a CA-BSI. Despite the increased risk of infection, placement of a central venous catheter is an important aspect of supportive care for the child with cancer; with the line being used to deliver medications, obtain laboratory specimens, provide transfusion support, and provide nutrition support.

PCMC institution-based and national benchmarking data indicate that PCMC's Hematology/ Oncology/Transplant service line has substantial opportunity for improvement. Recent research has validated the effectiveness of several interventions, which PCMC has not yet implemented as part of the institution-based standard of care. According to the research, the intervention most successful in reducing CA-BSIs is the Central Line Maintenance Bundle. All of the components of the Central Line Maintenance Bundle have been defined and tested at other children's hospitals around the United States. During 2010, PCMC's PICU and CICU were able to reduce their CA-BSI rates through implementation of these interventions.

2011 Goal for Primary Children's Medical Center

Reduce the nosocomial catheter-associated blood stream infection (CA-BSI) rate for Hematology/Oncology/Transplant service line patients to 4.86 infections per thousand line days. This will represent a 10% improvement from the current baseline of 5.40/1,000 line days (January through August 2010).

Entry Goal: 5% improvement (5.13/1,000 line days)
***Target Goal*:** 10% improvement (4.86/1,000 line days)
***Stretch Goal*:** 25% improvement (4.05/1,000 line days)

Clinical Processes to Meet the Goal: The team will study and implement NACHRI recommendations for a central line insertion bundle and central line maintenance bundle in the inpatient Immune Compromised Unit (ICS Unit). To do so, the team will need to change practice habits of physicians and nurses. This will include the implementation of intensified practices in relation to the care of central lines and the development of a system to support consistent practice among service line team members. The team will provide formal education, implement measurement and feedback systems, review and follow up on individual failures, and trouble-shoot as necessary.

Methodology: PCMC's infection control and prevention staff uses a standard methodology for collecting and reporting CA-BSI rates. The methodology is consistent with definitions set forth by the Centers for Disease Control and Prevention.

***Measurement Time Period*:** April - September 2011

ONCOLOGY CLINICAL PROGRAM

CONFIDENTIAL: This information is for an Intermountain Healthcare Peer or Care Review Committee to evaluate and improve health care. See Utah Code 26 25 1, et seq., or Idaho Code 39 1392, et seq.

Overview & Opportunity: The National Comprehensive Cancer Network recommends that Non-small cell lung cancer patients undergo a pre-operative PET/CT scan in combination with a bone scan prior to surgery. Published studies indicate that pre-operative imaging changes the patient's treatment plan in approximately 31% of cases. In order to receive high quality care, patients undergoing thoracotomy should have adequate pre-operative staging to ensure that their treatment is appropriate, adequate and of high quality. Currently at Intermountain the rates at which pre-operative PET/CT scans are conducted varies widely among facilities, regions and providers. Physician education and tracking under the direction of the oncology lung cancer development team will be utilized to reduce variation in physician practice and improve patient outcomes.

2011 Goal for the Oncology Clinical Program

Increase the percent of non-small cell lung cancer patients treated with curative thoracotomy at Intermountain Healthcare that have adequate pre-operative staging by undergoing a PET/CT or equivalent imaging scan to reach a system wide rate of 80%. The current baseline for patients receiving an adequate pre-operative staging scan is 69% (2008-2009 average).

Entry Goal: 75%
***Target Goal*:** 80%
***Stretch Goal*:** 85%

Clinical Challenges to Meet the Goal: The challenge for reaching this goal will be creating access for non-small cell lung cancer patients located in areas that do not have the necessary imaging equipment.

***Methodology*:**

- Proportion of non-small cell lung cancer patients undergoing curative thoracotomy who have appropriate imaging (as defined by national best practice guidelines) prior to surgery.
- Patient population comes from cancer registry and imaging procedure data comes from casemix.
- Patients must have surgery during the measurement period to be included.

***Measurement Time Period*:** First Quarter – Third Quarter 2011

INTENSIVE MEDICINE CLINICAL PROGRAM

Overview & Opportunity:
Stoke is a catastrophic diagnosis that impacts over 795,000 people in the United States each year. Stroke ranks number three among all causes of death, behind heart disease and cancer. Stroke is the leading cause of serious, long-term disability in the United States, leaving 30% of victims moderately to severely disabled. As a leading healthcare provider organization, we have a responsibility to decrease the incidence and consequences of stroke. Quick identification and early treatment of stroke is critical to best care and improved patient outcomes.

2011 Goal for the Intensive Medicine Clinical Program

Attain an improved composite rate of compliance to Stroke care (proportion of eligible stroke patients receiving 5 measures of appropriate care). Compliance rate of the combined areas of measure will reach 76% by August 1, 2011 and be maintained through September 30, 2011. Current compliance rate is 70% (end of 3rd Quarter 2010). Facilities participating in this goal are Intermountain Medical Center, Utah Valley, McKay- Dee, Dixie, LDS, and American Fork.

Entry Goal: 73 % composite compliance rate
***Target Goal*:** 76 % composite compliance rate
***Stretch Goal*:** 79 % composite compliance rate

Clinical Challenges to Meet the Goal:

- Acceptance and full implementation of the Stroke Care Process Model.
- Acceptance and use of the stroke data dictionary.
- Ability to collect and display appropriate data.

Methodology:

- Proportion of eligible stroke patients receiving 5 measures of appropriate care:
  Door to CT scout film
  Door to Thrombolytic
  Anti-thrombotic
  Anticoagulation (a-fib patients)
  Statins prescribed at hospital discharge
- Use of the system stroke care process model at all Intermountain hospitals.
- Data collection through "Get with the Guidelines."
- Present data on the Intensive Medicine Clinical Program website by system and review in each of our development team meeting for improvement.

***Measurement Time Period*:** April – September 2011

PEDIATRIC SPECIALTIES CLINICAL PROGRAM

Overview & Opportunity: Asthma is a serious – and sometimes life-threatening – disease of the lungs and airways. The numbers of children diagnosed with asthma continues to grow every year. Fortunately our ability to treat asthma is also growing and it is possible for children with asthma to have control of their disease. Through review of current inpatient practice, we have found that significant variation exists in the care provided to children hospitalized with asthma within Intermountain Healthcare. There is also evidence that these children and their parents / care givers may not receive adequate instruction to assist them to avoid future exacerbations.

2011 Goal for the Pediatric Specialties Clinical Program

70% of children between the ages of 2 and 17 years admitted to pediatric units (at the following facilities: Logan, McKay-Dee, Primary Children's, Riverton, American Fork, Utah Valley, and Dixie) with the primary diagnosis of asthma will be discharged with a written Asthma Action Plan and teaching documentation that includes these key areas: a) clinical overview including personal triggers; b) prescribed controller medication, c) how and when to take medications; and d) how and

when to seek medical care. The current baseline obtained from a third quarter 2010 chart review is 50.4%.

Entry Goal: 55%
***Target Goal*:** 70%
***Stretch Goal*:** 80%

Clinical Challenges to Meet the Goal: Appropriate use of the Intermountain Asthma Care Process Model (CPM) along with the new pediatric inpatient algorithms, order sets, and teaching tools will facilitate improvement of medical care for hospitalized children with asthma. The physicians will establish a written Asthma Action Plan. This is a tool that is meant to guide the child's management of the disease at home. The respiratory therapists and nurses at each facility will collaborate to provide individualized education prior to discharge. The education will be based on a needs assessment that will identify knowledge gaps and skill deficits of the patient and family, and they include the individualized Asthma Action Plan.

***Methodology*:** Patients will be selected from the Enterprise Data Warehouse based on age and asthma as a primary diagnosis. The outcome will be determined by chart review indicating the presence of a written Asthma Action Plan and teaching documentation for all pediatric patients between the ages of 2 and 17 years admitted to the pediatric units at Logan, McKay-Dee, Primary Children's, Riverton, American Fork, Utah Valley, and Dixie. These tools will be audited for presence of each of the key areas described above. The action plan and teaching documentation compliance will be tracked monthly and completion of each document will contribute 0.5 goal credit for each patient.

***Measurement Time Period*:** January - September 2011

BEHAVIORAL HEALTH CLINICAL PROGRAM

Overview & Opportunity: Rates of obesity among patients with mental health disorders is higher than in the general population, and is accompanied by medical comorbidities including type 2 diabetes mellitus, cardiovascular conditions, and dyslipidemia. This tendency is due in part to poor dietary choices and a sedentary lifestyle, but is also due to the use of antipsychotic medications. The Behavioral Health Clinical Program will address this issue by monitoring weight routinely during outpatient, inpatient, and residential care, and by providing appropriate weight management and nutrition education to identified patients.

2011 Goal for Behavioral Health Clinical Program

Measure weight change and provide education for overweight behavioral patients in all settings: acute inpatient, residential, day treatment, and outpatient clinics excluding chemical dependency patients. This is a composite goal that consists of achieving a target for a percentage of patients whose weight is measured and recorded in HELP1 or HELP2 with a secondary target for educating patients with a BMI >25 in adults and >85th percentile in children and adolescents. The 2010 BHCP goal implemented weight measurement in all parts of the continuum, whereas the 2011 continuation of the goal will focus on educational intervention for identified patients. September 2010 baseline data indicates that 87% of overweight behavioral patients in all settings have recorded weights, but less than 3% of overweight behavioral patients have documented education.

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Entry Goal:	90% of patients with recorded weights; 20% of overweight patients will have education
Target Goal:	90% of patients with recorded weights; 30% of overweight patients will have education
Stretch Goal:	90% of patients with recorded weights; 40% of overweight patients will have education

Clinical Processes to Meet the Goal: The challenge to achieving this goal is staff education and established processes to measure and document education. Patient compliance with medication and treatment appointments will also impact this goal.

Methodology: Weight is measured and recorded in the EMR (inpatient HELP1 and outpatient HELP2) for overweight behavioral patients in all settings: acute inpatient, residential, day treatment, and outpatient clinics excluding chemical dependency patients. Inpatients will have one weight measured at admission. Outpatients will have two recorded weights in any six-month period. The second half of the board goal is to have documentation that standardized education has taken place and is recorded in the PROBLEMS section of the HELP2 system for outpatients and in the appropriate section of the HELP1 system for inpatients. Patients to be included are all patients with a BMI >25 in adults and >85th percentile in children and adolescents.

***Measurement Time Period*:**

- Recorded weights: inpatients--one recorded weight at admission and outpatients--two recorded weights in any six-month period
- Patient Education: Third Quarter 2011

SELECTHEALTH

Overview & Opportunity: Strengthening primary care is a goal for practices, health plans, health systems and health policy makers. SelectHealth, the Medical Group, and Central Utah Medical Clinic have piloted three medical homes in 2010. The pilots need to be scalable to accommodate Accountable Care Organizations (ACOs) and to facilitate practice transformation. The medical home pilots will eventually be increased so that all urban regions will be represented by medical group sites and two more affiliated sites will be added. This will require further development of financial models, reporting, care coordination, and collaboration between physicians and SelectHealth. These pilots should help prepare physicians, SelectHealth and Intermountain for the future healthcare environment of ACOs.

2011 Goal for SelectHealth

Increase the number of medical home sites, increase SelectHealth and physician collaboration, and improve patient satisfaction, quality and efficiency. SelectHealth and the clinic sites will jointly agree on satisfaction, quality and efficiency goals. They will complete collaborative projects to achieve the goals. The results will be measured and reported to the clinics.

Entry Goal:	Have ten medical home pilots with satisfaction, efficiency, and quality goals for existing standard measures by March 31, 2011.

Target Goal:	Complete one collaboration project at each new medical home site by September 30, 2011.
Stretch Goal:	Meet 90% (7/9) satisfaction, efficiency, and quality goals for the existing medical home clinics by September 30, 2011.

Clinical Challenges to Meet the Goal: It is difficult for busy practices to transition to new methods of delivering care while working under current models of payment, staffing and technology. Their efforts do not always produce short term measureable results in all areas.

Methodology: Goals will be documented in the minutes of the SelectHealth clinic site meetings. The measurements will be based on the PPQ survey, SelectHealth quality measures, and SelectHealth claims data base.

Measurement Time Period: July - September 2011

CMS VALUE BASED PURCHASING

Overview & Opportunity: Value-Based Purchasing (VBP) is a proposal by the Centers for Medicare and Medicaid Services (CMS) to extend current clinical quality and patient perception public reporting into a Pay for Performance Model. The final rule is expected to be published in May 2011.

- CMS currently withholds 2% of hospitals' Annual Payment Update, and this is earned back by reporting core measures and satisfaction data.
- VBP will withhold an additional 1% of hospitals Annual Payment Update which is earned back by achieving high levels of performance or improvement. This percentage increases annually until reaching a 2% target in 2017.
- The first year of VBP will represent 70% clinical process measures (core measures) and 30% patient experience (HCAHPS satisfaction). The second year will add outcomes measures.
- VBP will be publically reported on CMS's hospitalcompare.hhs.gov web site.

As a system, many Intermountain measures are below the CMS Benchmarks for both Clinical Measures and Patient Perception Domain Measures. Without significant improvement, Intermountain has both financial and reputational risks.

2011 Goal for Value-Based Purchasing

Attain a statistically significant improvement in the CMS Value-Based Purchasing Measures for the system by the end of the fourth quarter 2011. Comparable statistically significant facility targets will by calculated using facility baseline data (Q4-2010). Goal attainment will be measured by facility.

	Entry Goal	***Target Goal***	***Stretch Goal***
Cardiovascular	***97.9***	***98.2***	***98.8***
Pneumonia	***95.5***	***96.0***	***96.5***
Surgical	***95.8***	***96.0***	***96.3***

Clinical Challenges to Meet the Goal:

Thresholds for scoring are very high using CMS national comparison.

- Most CMS clinical measures benchmark (top 10%) are 100% and median are >97%.
- For some individual measures, opportunity for improvement is very small (1 – 2 cases/quarter).

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Methodology:

- A composite measure by category (see above) will be calculated to include the sum of numerator and denominators for each topic. System/facility targets will be defined by category.
- Where a topic cannot be improved statistically because of low volumes, a clinical improvement will be defined.
- Goal will be weighted as 30% Cardiovascular, 30% Pneumonia, and 40% Surgical.
- Measures with less than 3 cases per quarter will be excluded from calculations.
- PCMC and Critical Access Hospitals (Cassia, Delta, Fillmore, Heber Valley, Sanpete) are excluded from the Clinical Measures.

Measurement Time Period: October – December 2011

ADDENDUM

WOMEN & NEWBORNS CLINICAL PROGRAM

All Intermountain Healthcare facilities with at least 10 high-risk antepartum or Cesarean delivery patients per month need to meet the target percentage as defined in the goal of the Women & Newborns Clinical Program.

CARDIOVASCULAR CLINICAL PROGRAM

All Intermountain Healthcare facilities need to meet the target percentage as defined in the goal of the Cardiovascular Clinical Program.

SURGICAL SERVICES CLINICAL PROGRAM

LDS Hospital, Intermountain Medical Center and Dixie Regional Medical Center need to meet the target percentage as defined in the goal of the Surgical Services Clinical Program.

PATIENT SAFETY

Entity	Fall Category	Number of Falls	Patient Days	Rate per 1000	Statistically Significant Reduction	Falls Reduction to Meet Target Goal*	Entry	Target	Stretch
Intermountain System	Total Falls	1866	423045	4.41	4.21	84	4.26	4.21	4.17
Rural Region	Total Falls	113	17074	6.62	5.40	21	5.47	5.40	5.34
Southwest Region	Total Falls	356	60875	5.85	5.24	37	5.30	5.24	5.18
Urban Central Region	Total Falls	713	164789	4.33	4.01	52	4.05	4.01	3.97
Urban North Region	Total Falls	334	89933	3.71	3.32	36	3.35	3.32	3.28
Urban South Region	Total Falls	350	90373	3.87	3.47	37	3.51	3.47	3.43

Entry goal = 1 percentage point above statistically significant rate
Target goal = Statistically significant rate
Stretch goal = 1 percentage point below statistically significant rate

* Numbers are based on the patient days used in this spreadsheet. As the patient days vary, so will the number of reduced falls needed to meet the goal.

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ONCOLOGY CLINICAL PROGRAM

All Intermountain Healthcare facilities need to meet the target percentage as defined in the goal of the Oncology Clinical Program, with the Regional expectations to: present the Clinical Board Goal to key physician and clinical leaders, utilize clinical report tools, communicate regional compliance to key physicians and clinical leaders, and document and report regional actions supporting goal.

INTENSIVE MEDICINE CLINICAL PROGRAM

Facility	Entry goal	Target goal	Stretch goal
System	73%	76%	79%
American Fork	50%	53%	56%
Dixie Regional	72%	75%	78%
IMC	76%	79%	82%
LDS	68%	71%	74%
McKay-Dee	75%	78%	81%
Utah Valley	73%	76%	79%

PEDIATRIC SPECIALTIES CLINICAL PROGRAM

Facility/Region/System	Red (<Value)	Yellow (not Red or Target)	Target (>=Value)	Stretch (>=Value)
System	55%	55-69%	70%	80%
Urban North Region	55%	55-59%	60%	80%
Primary Children's	55%	55-69%	75%	80%
Urban Central Region	55%	-	55%	80%
Urban South Region	55%	55-58%	59%	80%
South West Region	55%	-	55%	80%
Rural	NULL	NULL	NULL	NULL
Alta View Hospital	NULL	NULL	NULL	NULL
American Fork Hospital	55%	-	55%	80%
Bear River Valley Hospital	NULL	NULL	NULL	NULL
Cassia Regional Medical Center	NULL	NULL	NULL	NULL
Delta Community Medical Center	NULL	NULL	NULL	NULL
Dixie Regional Medical Center	55%	-	55%	80%
Fillmore Community Medical Center	NULL	NULL	NULL	NULL
Garfield Memorial Hospital	NULL	NULL	NULL	NULL

CONFIDENTIAL: This information is for an Intermountain Healthcare Peer or Care Review Committee to evaluate and improve health care. See Utah Code 26 25 1, et seq., or Idaho Code 39 1392, et seq.

Intermountain Medical Center	NULL	NULL	NULL	NULL
LDS Hospital	NULL	NULL	NULL	NULL
Logan Regional Hospital	55%	-	55%	80%
McKay-Dee Hospital	55%	55-59%	60%	80%
Orem Community Hospital	NULL	Null	NULL	NULL
Park City Medical Center	NULL	NULL	NULL	NULL
Primary Children's Medical Center	55%	55-69%	70%	80%
Riverton Hospital	55%	-	55%	80%
Sanpete Valley Medical Center	NULL	NULL	NULL	NULL
Sevier Valley Medical Center	NULL	NULL	NULL	NULL
The Orthopedic Specialty Hospital	NULL	NULL	NULL	NULL
Utah Valley Regional Medical Center	55%	55-59%	60%	80%
Valley View Medical Center	NULL	NULL	NULL	NULL

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