The Journey to High Value Healthcare

North Carolina Association of Healthcare Quality
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The Illusion

Today's Topics

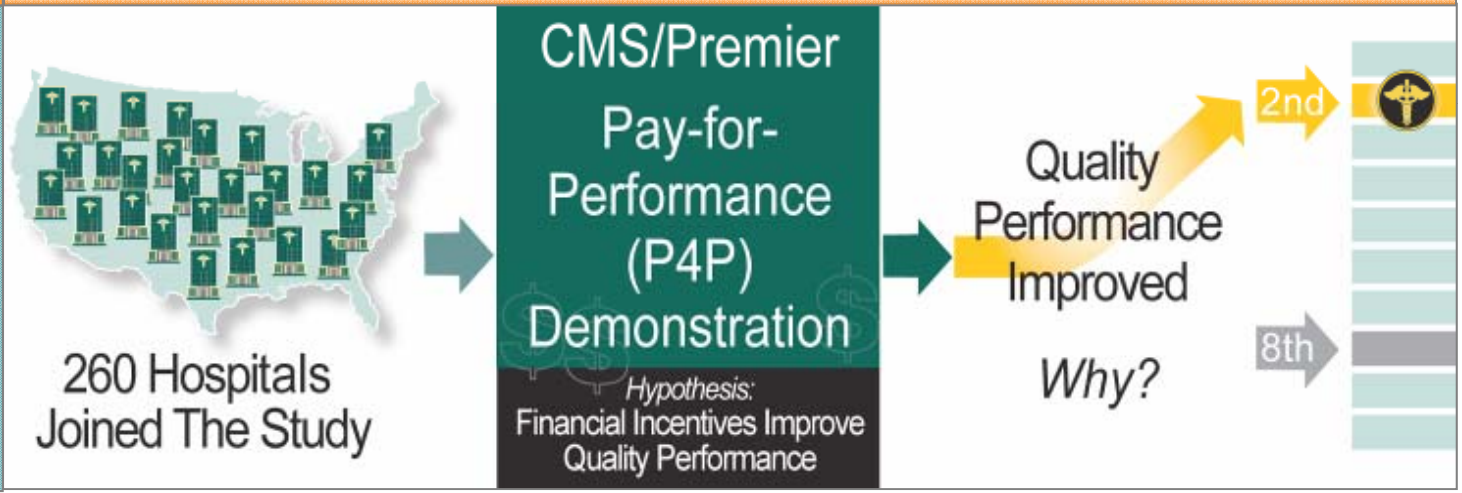
- Hospital Quality Incentive Demonstration ("HQID")
  - Background
  - Results
  - Learnings
  - P4P in the United Kingdome
- QUEST
  - Background/Alignment with Value Based Purchasing
  - Results
  - Collaborative Execution
  - Looking to the Future
- Accountable Care Organizations

Hospital Quality Incentive Demonstration

Overview of Premier/CMS P4P project

Premier is leading the first national CMS pay-for-performance demonstration for hospitals. More than 260 Premier hospitals participate voluntarily.

Hypothesis	Financial incentives / transparency improve hospital quality & performance



Findings

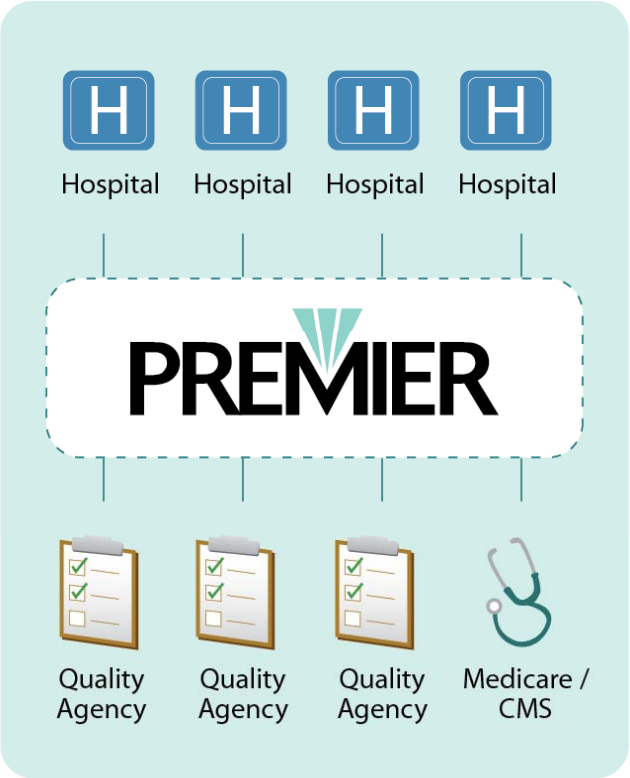
- Financial incentives did focus hospital executive attention on measuring and improving quality.
- Hospitals' performance has improved continuously over time.

Hospital Quality Incentive Demonstration (HQID)

- Three year demonstration (October 2003 – September 2006)
- 260 hospitals in 37 states volunteered to participate
- Clinical Conditions
  - Heart attack (Acute myocardial infarction (AMI))
  - Heart bypass surgery (Coronary artery bypass graft (CABG))
  - Heart failure (HF)
  - Community acquired pneumonia (PN)
  - Hip and knee replacement surgery (Hip/Knee)
- Quality Measures: 33 nationally recognized measures – mostly process measures with some outcome measures
- Composite Quality Score (CQS) – sum of numerators/sum of denominators

Premier's Role in HQID

- Participate in design of pay-for-performance program
- Collect, aggregate, and analyze results
- Benchmark status of all hospitals in study
- Identify hospital's opportunities for improvement
- Document and disseminate best practice implementation tools among participants
- Assist participants in executing best practices
- Over site for operational processes / timelines with CMS contractors
- Knowledge base for hospital staff on measures & abstraction of charts
- Identify & propose resolutions to process issues
- Provide project progress reports for various government agencies



Financial incentives

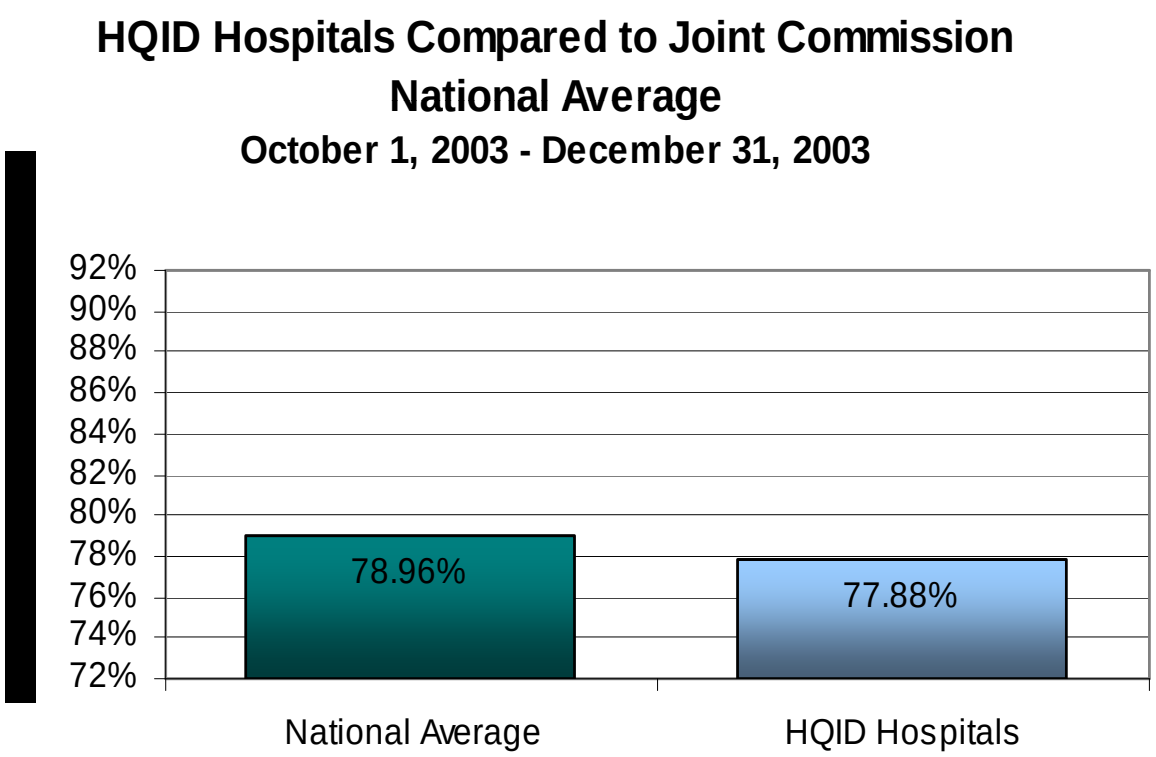
- Top Decile performance – additional 2% Medicare reimbursement for clinical condition within each year of the demonstration in which a hospital achieved
- Second Decile performance – additional 1% Medicare reimbursement for clinical condition within each year of the demonstration in which a hospital achieved
- Top 50% performance - public recognition on CMS website
- Penalty - Bottom 2 Deciles could lose reimbursement in Year 3 only

HQID Hospitals Started Project at National Average

HQID hospitals did not have higher quality ratings* than national hospitals overall at the beginning of the project

*Composite process score

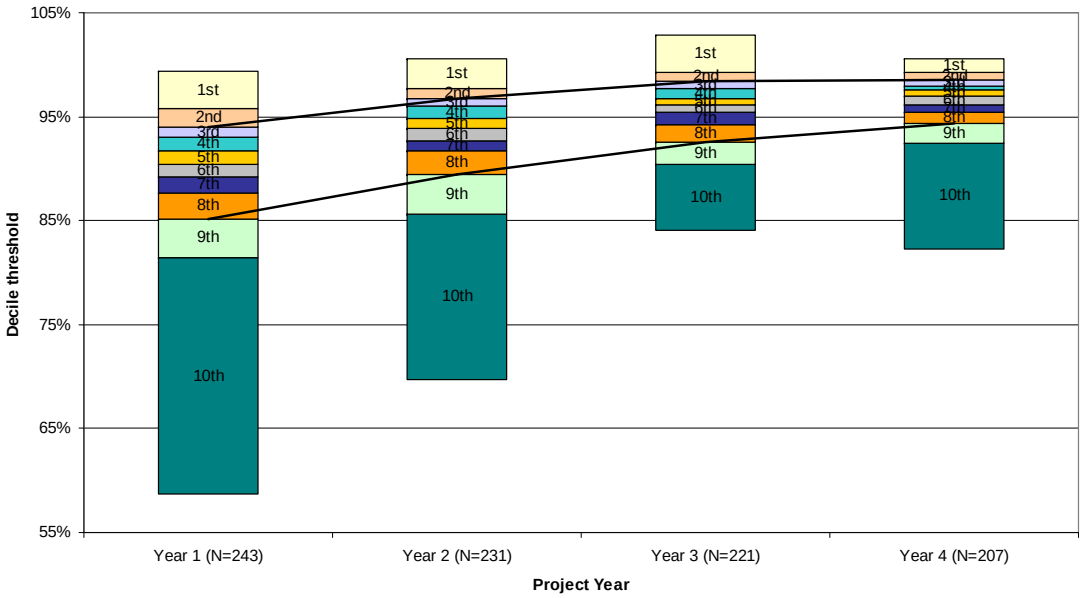
A composite of 14 measures shared in common between HQID and the Joint Commission Comparative for the first quarter of the project shows P4P hospitals performing below the nation as a whole.



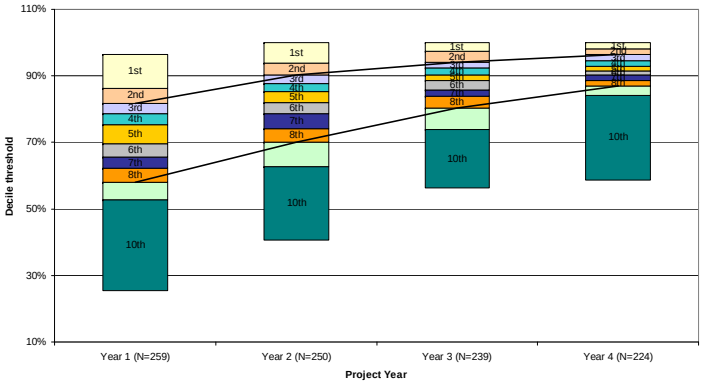
Over Time…Improvement Across All HQID Participants

- Quality improvement across all hospitals
- Variation in hospital performance decreased

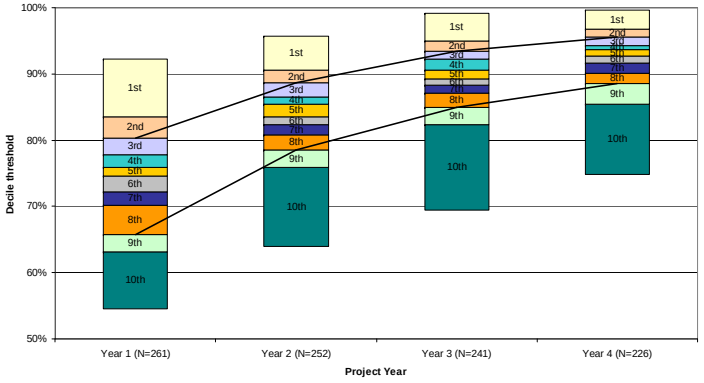
AMI CMS HQID Quality Score Threshold Changes by Year



Heart Failure CMS Quality Score Threshold Changes by Year



Pneumonia CMS Quality Score Threshold Changes by Year



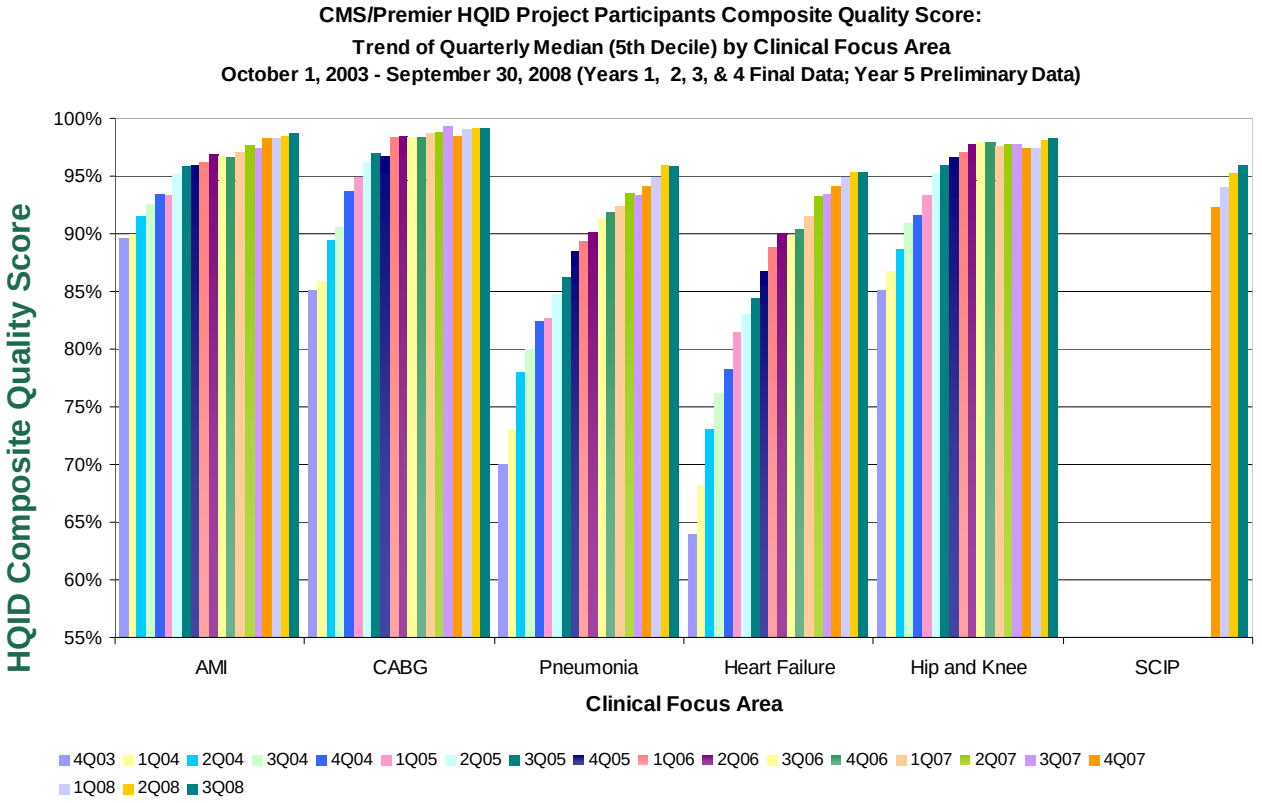
Dramatic and Sustained Improvement

Avg. improvement across all 5 clinical areas for median CQS (20 quarters)
18.70%

Clinical Area	Improvement (percentage points)
AMI	**9.1%**
CABG	**14.0%**
Pneumonia	**25.8%**
Heart Failure	**31.4%**
Hip & Knee	**13.1%**

$24.5M Awarded in first 3 years!

CMS HQID Composite Quality Score



Improvement and Savings

Avg. cost improvement per patient across all clinical areas
$1,063

Clinical Area	Improvement
AMI	$1,599
CABG	$1,579
Pneumonia	$811
Heart Failure	$1,181
Hip Replacement	$744
Knee Replacement	$463

Avg. improvement in mortality across four clinical areas
1.87%

Clinical Area	Improvement
AMI	2.27%
CABG	0.95%
Pneumonia	2.39%
Heart Failure	1.86%

If all hospitals in the nation were to achieve this improvement, the estimated cost savings would be greater than *$4.5 billion annually* with estimated *70,000 lives saved per year*

Hospital Quality Incentive Demonstration (HQID) – Extension

- Financial incentives modifications (can only receive two of the three below)
  - Attainment – If achieve CQS greater than year 2 median CQS for each clinical condition
  - Top Performer – Top 20% achievers within each clinical condition will receive an award payment
  - Improvement – Those hospitals with largest % quality improvements in each clinical condition (from the last 2 years) will receive an award payment
  - Penalties assessed each year for bottom two decile performance (9th and 10th) with the baseline being two years prior
    - Penalty CQS's capped at 85%
  - Reward Sharing – share quality incentives with physicians and staff

- Award Payment set at $12M per year

- Results for all participants shared publicly.

What we learned. . .

- Requires organizational commitment to quality
  - Board
  - Executive Team
  - Staff
- System redesign is critical
  - Stabilization, integral to the system and care delivery process
- Effective changes can be simple and inexpensive

Overall Lessons Learned – The “How’s”

- “Quality” core value of institution
- Priority of executive team
- Clinician engagement
- Improvement methodology
- Prioritization methodology
- Dedicated resources
- Committed “knowledge transfer”

Better outcomes are associated with hospitals where...

1. The Board spends >25% of time on quality issues ($p = 0.009$);
2. The Board receives a formal quality performance measurement report ($p=0.005$);
3. There is a high level of interaction between the board and the medical staff on quality strategy ($p=0.021$);
4. The senior executives' compensation is based in part on QI performance ($p=0.008$);
5. The CEO is identified as the person with the greatest impact on QI ($p=0.01$), especially when so identified by the QI executive ($p<0.001$).

Kroch, E. A., *et al*. (2006). "Hospital Boards and Quality Dashboards." *Journal of Patient Safety* **2**(1): 10-19.
Vaughn, *et al*. (2006). "Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results." *Journal of Patient Safety* **2**(1): 2-9.

P4P in the United Kingdom

- "Advancing Quality" is the United Kingdom's first hospital-based pay-for-performance effort.

- Uses Premier's HQID project as a model for improving patient care.

- Received the 2009 HSJ Awards' top honor for "Using Data to Improve Care."

ADVANCING QUALITY
GOOD BETTER BEST

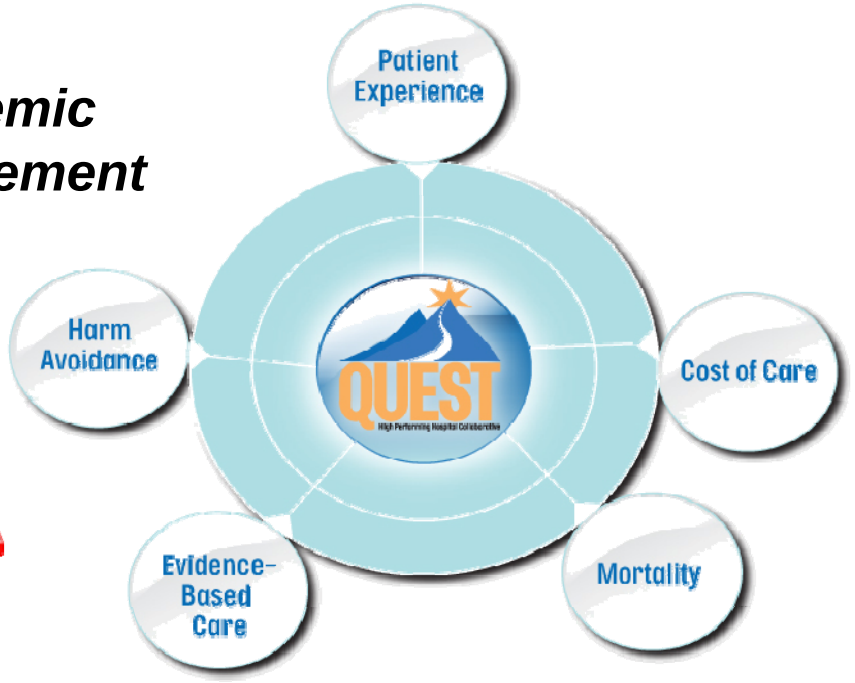
QUEST

Leading the way in **QU**ality, **E**fficiency,
Safety, and **T**ransparency

Background of QUEST/ Alignment with Value Based Purchasing

QUEST: A Progression from HQID

Systemic Improvement

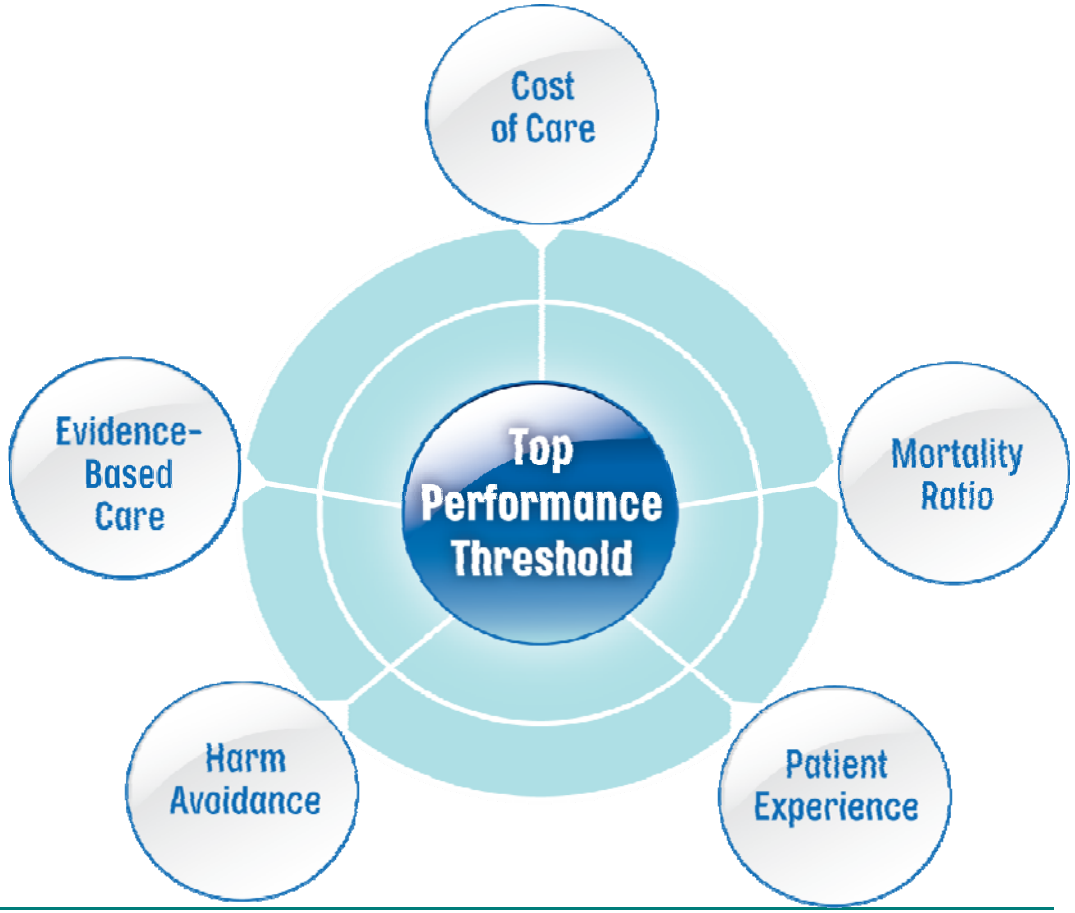


Process Improvement

Framework for High-Value Healthcare

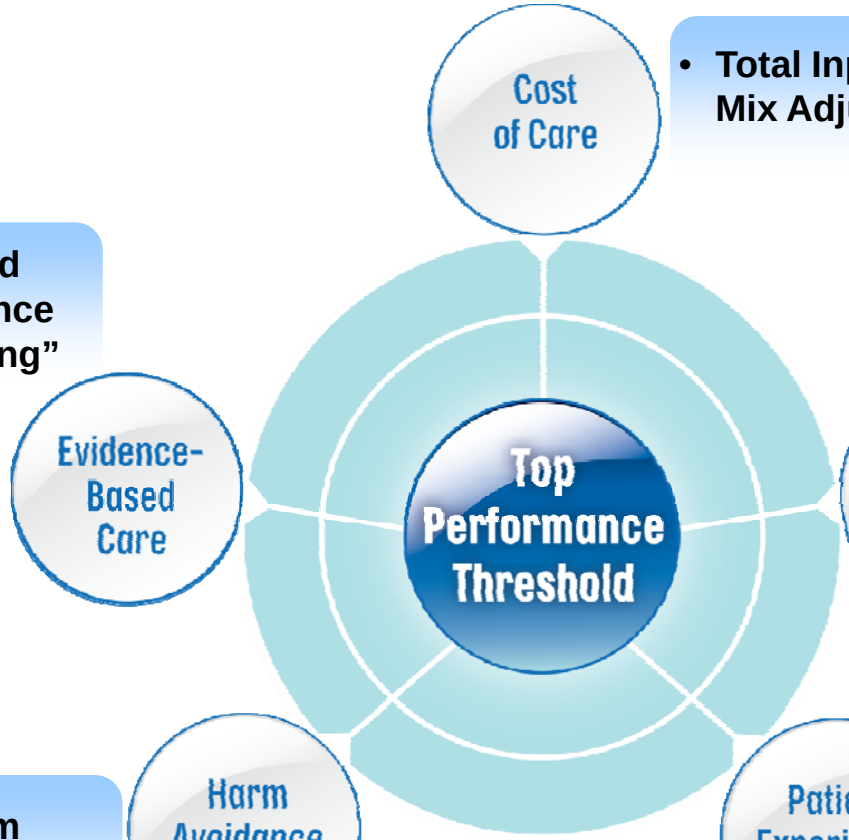
Underlying Foundations for the Framework:

- Measurement
- Senior Leader Engagement



Defining value in healthcare.

Measuring within Each of the QUEST Domains



- **Total Inpatient Cost per Case Mix Adjusted Discharge**
- **Evidence-Based Care Performance % "All or Nothing"**
- **Hospital Level Risk Adjusted Mortality (O/E Ratio)**
- **Composite Harm Index (30 measures)**
- **Global Composite Perception Score (HCAHPS Top Box Global Measures Composite Score)**

Value Based Purchasing
Underlying Premise and Overall Goals

Underlying Premise: CMS must transform itself from a *passive payer* of services to an *active purchaser* of care.

Goals of VBP:

- **Improve clinical quality**
- **Address overuse, misuse and underuse of services**
- **Encourage patient centered care**
- **Reduce adverse events and improve patient safety**
- **Avoid unnecessary costs in the delivery of care**
- **Invest in structural components of care and the re-engineering of care system wide**
- **Make performance results transparent to and usable by consumers**
- **Avoid creating new and eliminate existing disparities in care**

Source: U.S. Department of Health and Human Services Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program; November 21, 2007

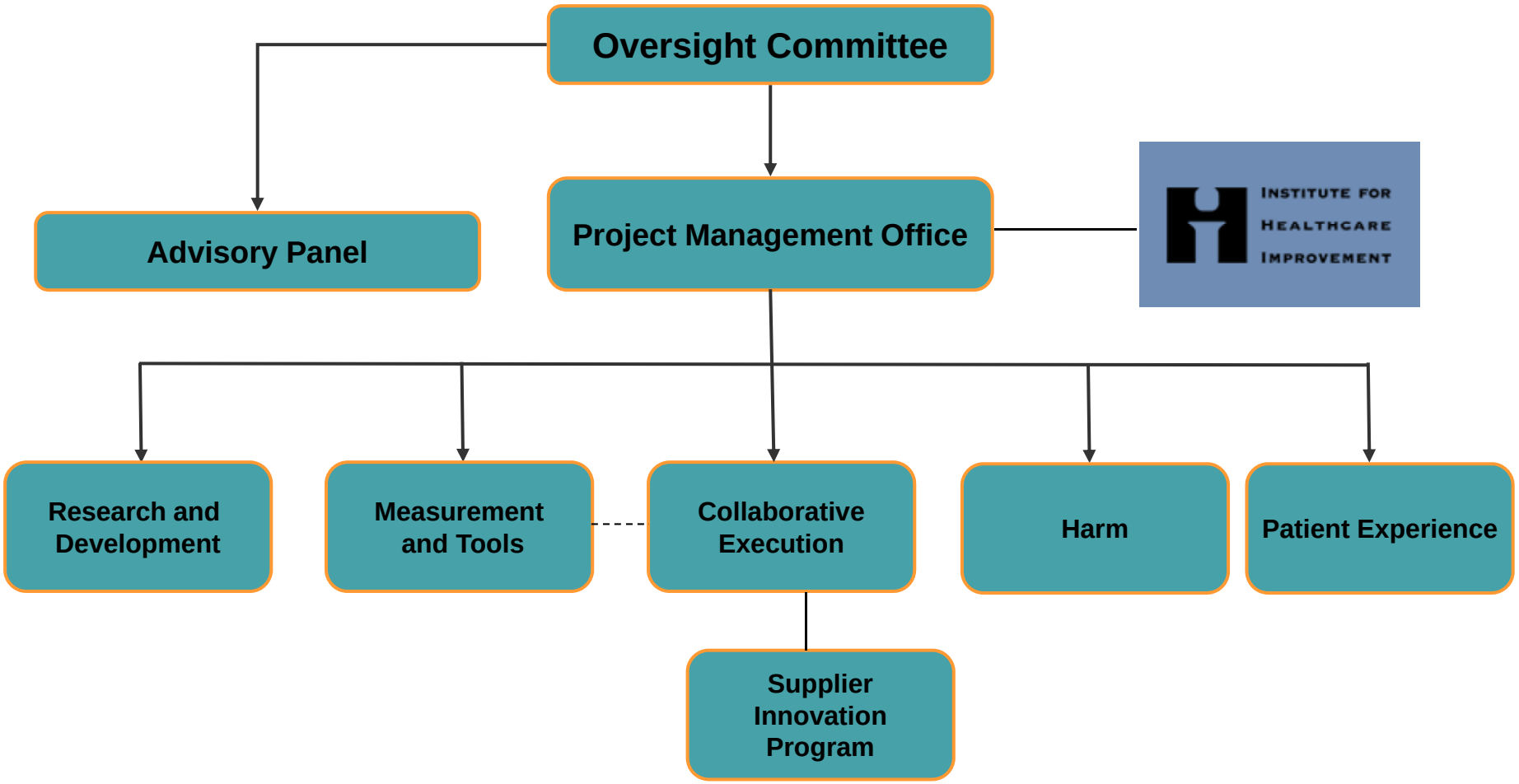
Value Based Purchasing
Proposed Measures

- **Initial Measures**:
  - **Process of Care** (Evidenced Based Care for AMI,HF, Pneumonia, and SCIP)
  - **Outcomes** (30 Day Mortality Rates)
  - **Patient Centered Care (**HCAHPS)
- **Will Readmissions and Hospital Acquired Conditions be added? YES!**

- **Future Measures:**
  - **Patient Safety (**More Hospital Acquired Complications)
  - **Emergency Care**
  - **Efficiency (**Cost of Care/Waste)
  - **Care Coordination**
  - **Outpatient Measures**

Source: U.S. Department of Health and Human Services Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program; November 21, 2007

QUEST: Governance



Thought Leadership, Advocacy, Collaboration

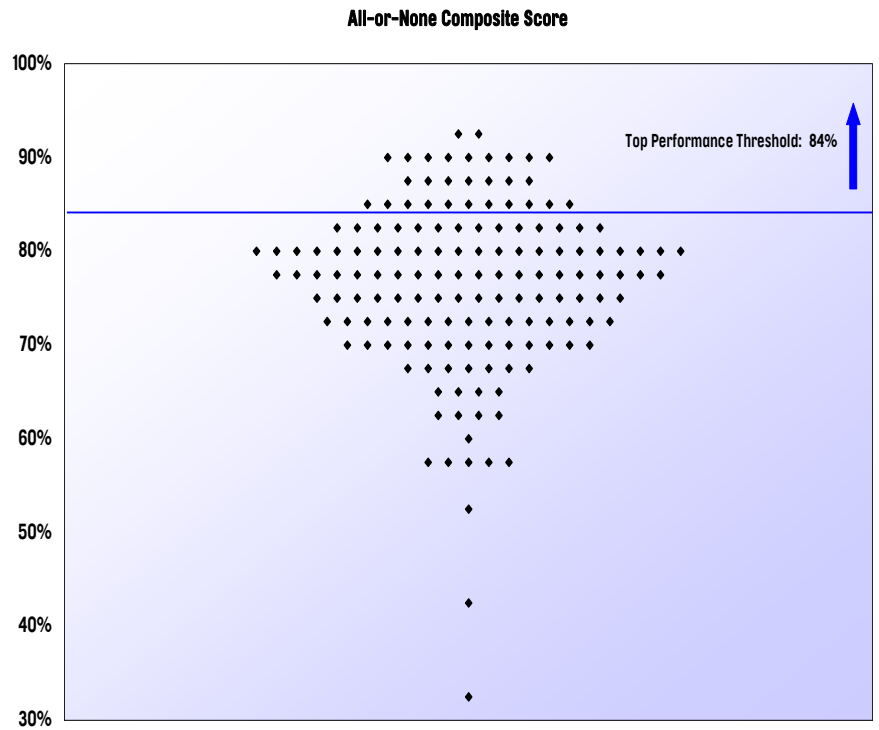
QUEST Advisory Panel

- Agency for Healthcare Research and Quality (AHRQ)
- Alliance for Nursing Informatics, University of Minnesota
- American Board of Internal Medicine
- American College of Surgeons
- American Health Information Management Association
- American Heart Association
- American Hospital Association
- American Society for Healthcare Risk Management (ASHRM)
- Blue Cross Blue Shield Association (BCBSA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS
- Institute for Healthcare Improvement (IHI)
- International Center for Nursing Leadership University of Minnesota
- John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
- National Business Coalition on Health
- National Patient Safety Foundation (NPSF)
- National Quality Forum
- Office of the National Coordinator for Health Information Technology
- The Commonwealth Fund
- The Joint Commission
- The Rand Corporation

QUEST Performance Results To Date

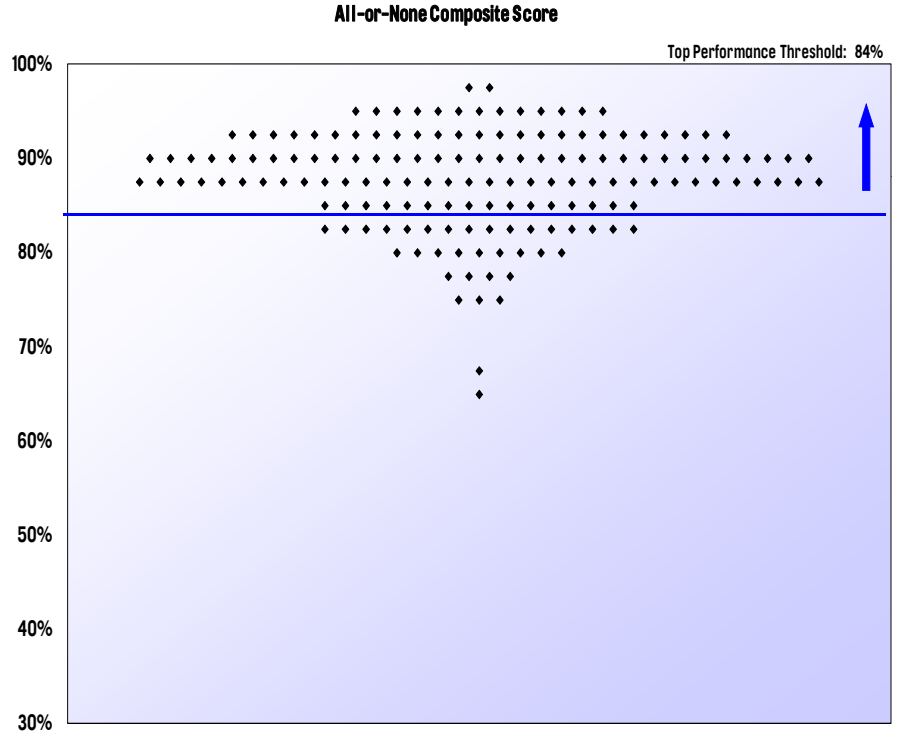
QUEST Results:
Distribution Comparison: Evidenced Based Medicine

Baseline (3Q 2006 – 2Q 2007)



*This Distribution Graph shows the range of variation for the Evidence-Based Care Rates of the QUEST charter members. Each dot represents one hospital. The plotted values are based on rounded values.

3Q 2008 - 2Q 2009



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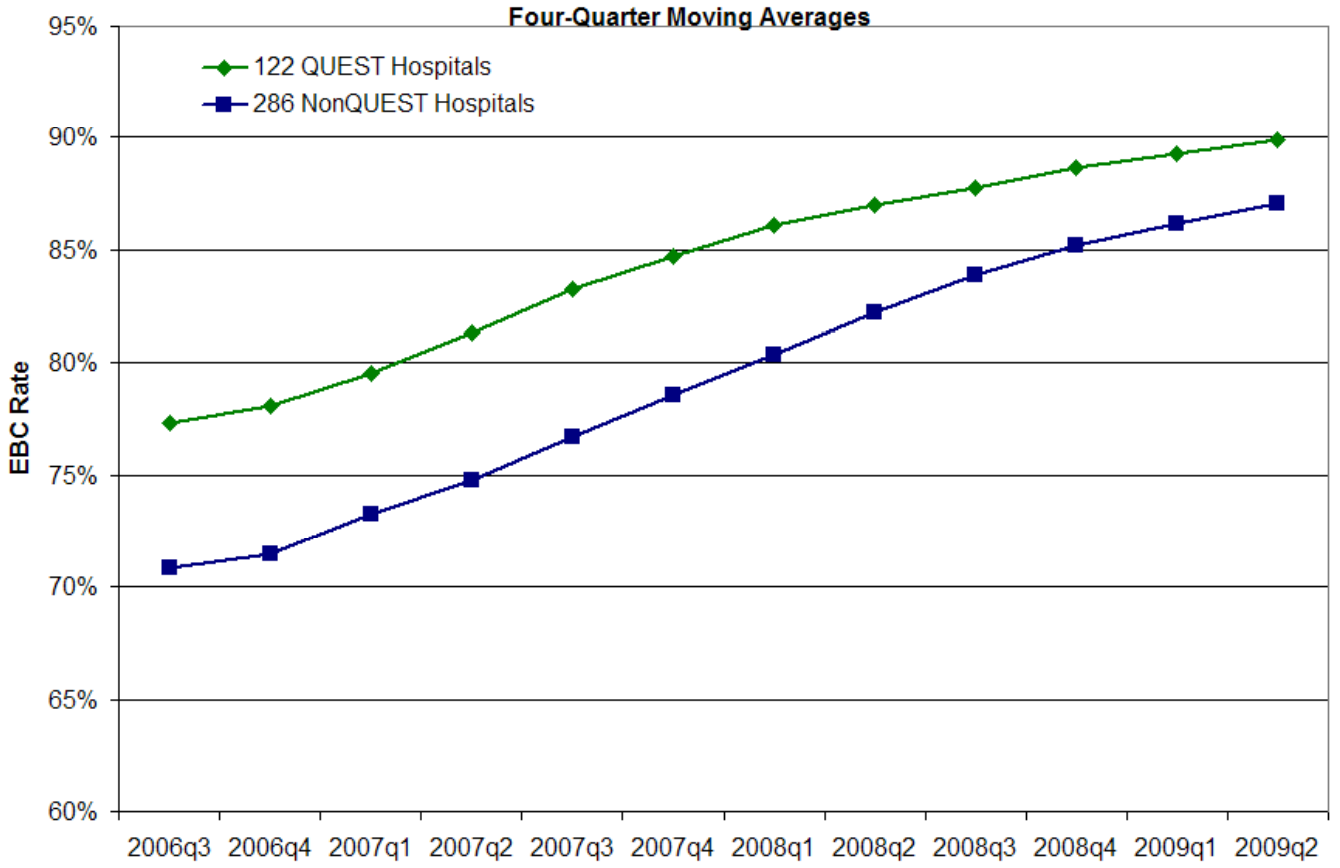
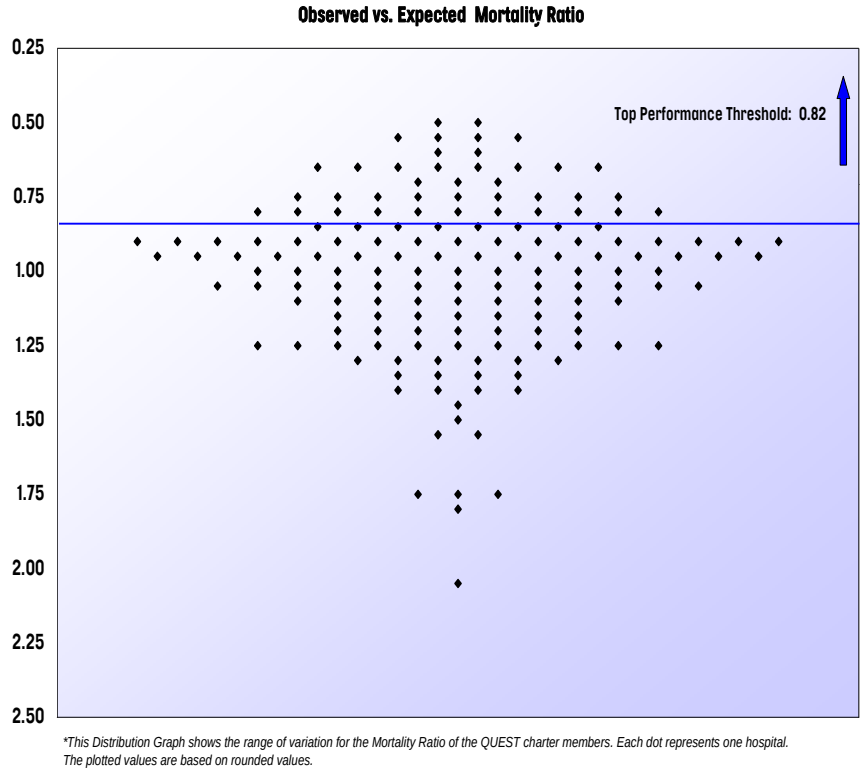
QUEST Participants Compared to Non-Participants: Evidence-Based Care Trends



86% of QUEST hospitals in the top performance threshold

QUEST Results:
Distribution Comparison: Mortality Ratio

Baseline (3Q 2006 – 2Q 2007)



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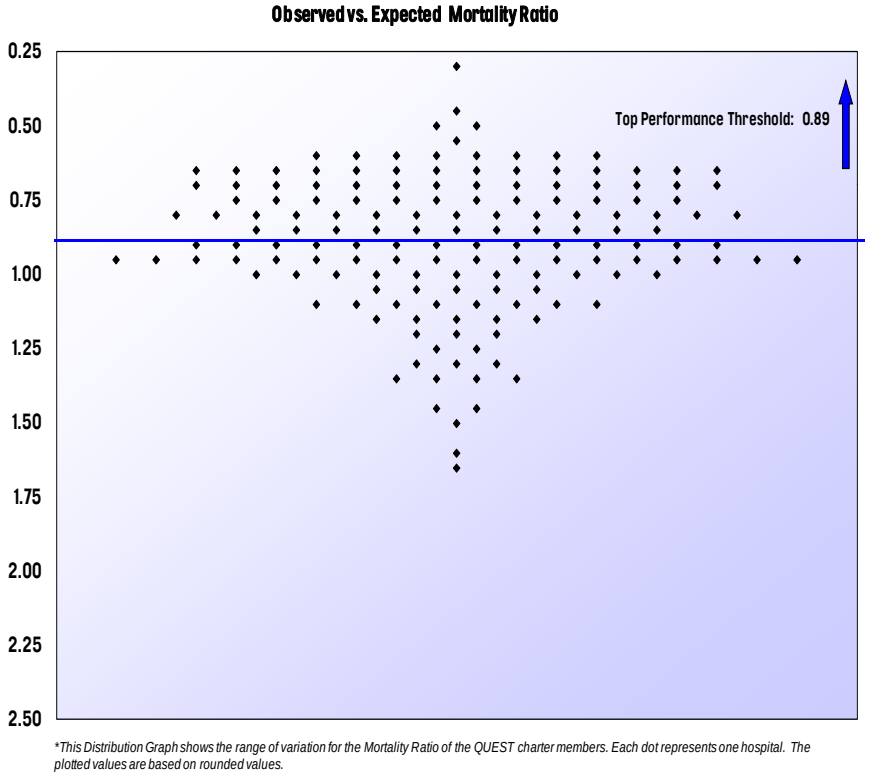
3Q 2008 - 2Q 2009



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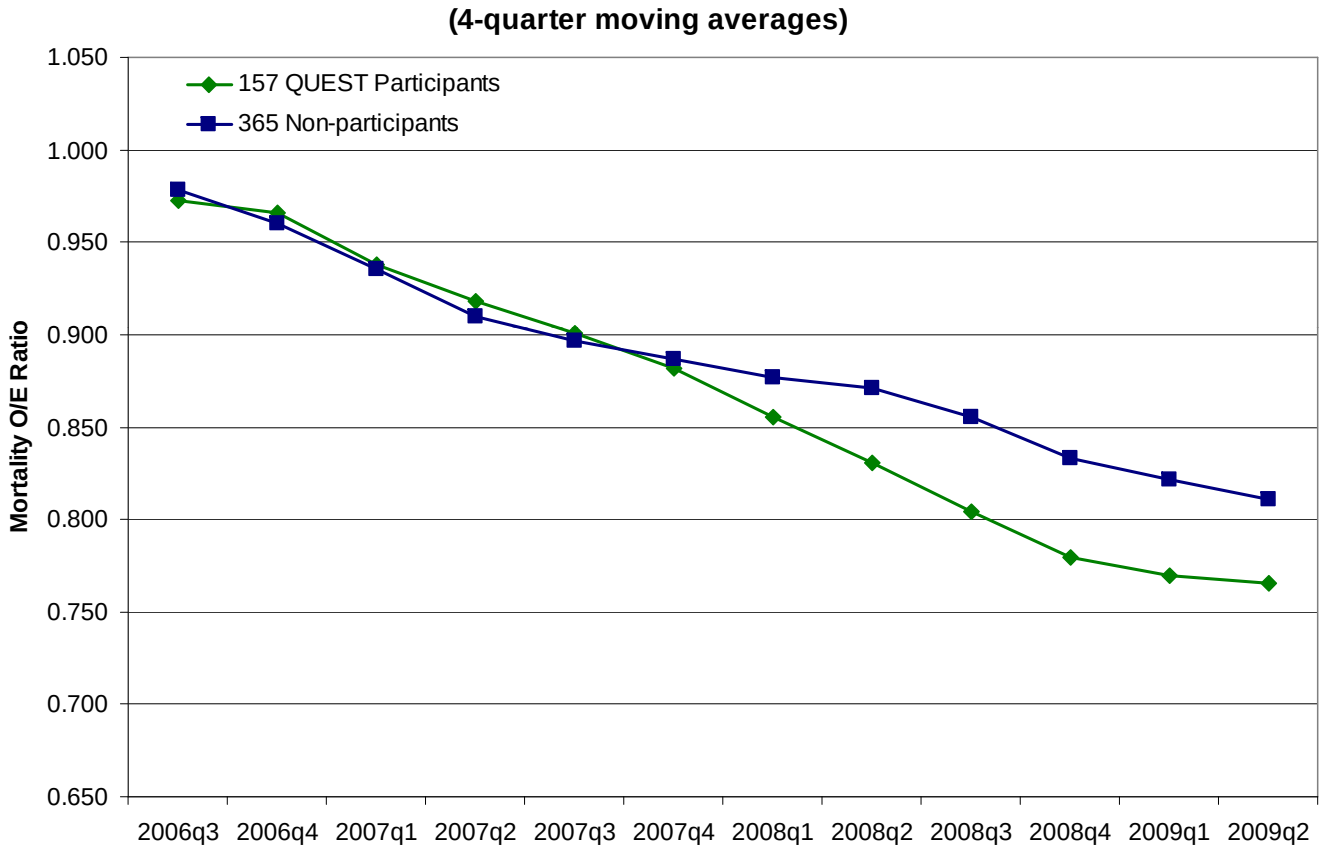
Please note that the TPT was adjusted from 0.82 in the baseline to 0.89 for the 2q08-1q09 due to the recalibration of the CareScience risk model for 2009 data.

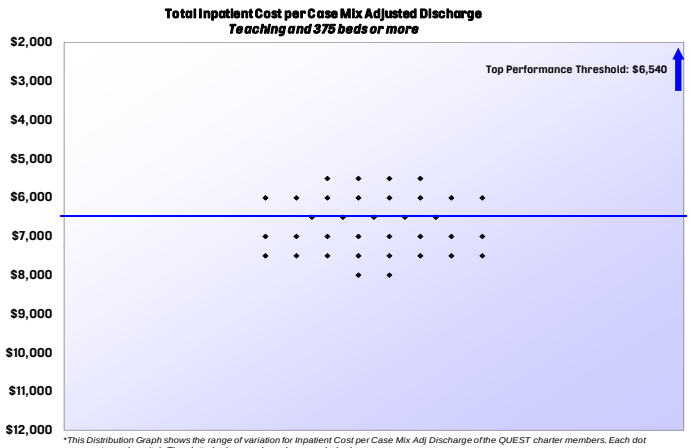
QUEST Participants Compared to Non-Participants: Mortality Trends



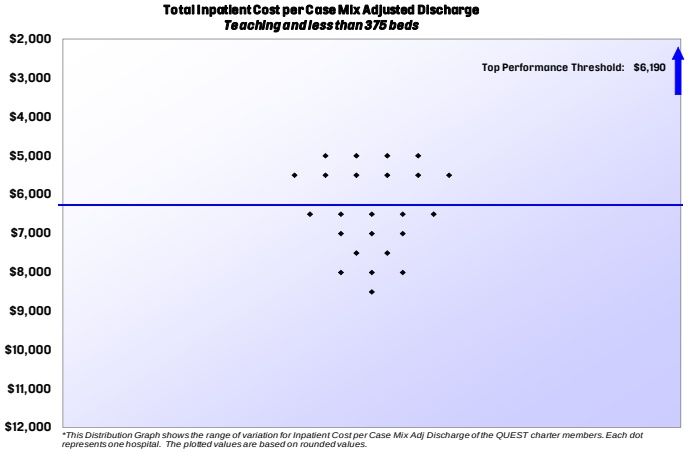
58% of QUEST hospitals in the top performance threshold

QUEST Results:
Distribution Comparison: Cost of Care – Teaching

Baseline (3Q 2006 – 2Q 2007)

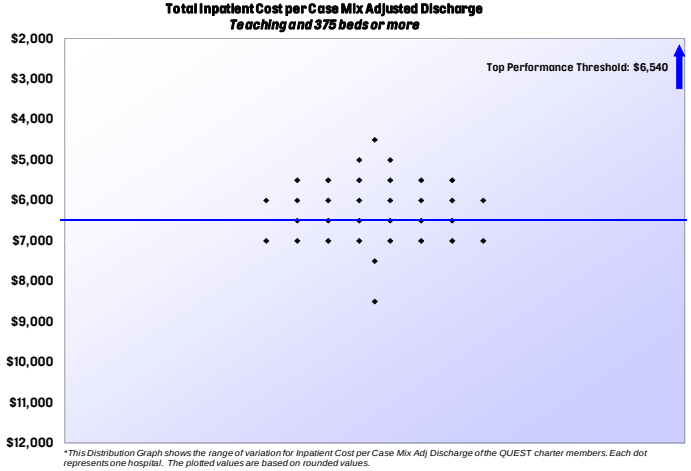


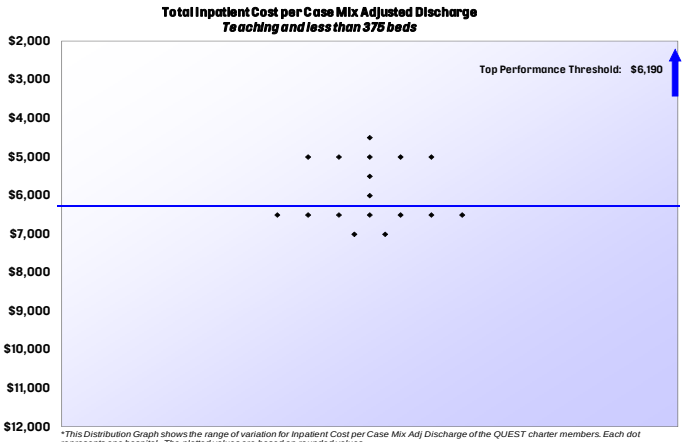
>= 375 Beds



< 375 Beds

3Q 2008 - 2Q 2009



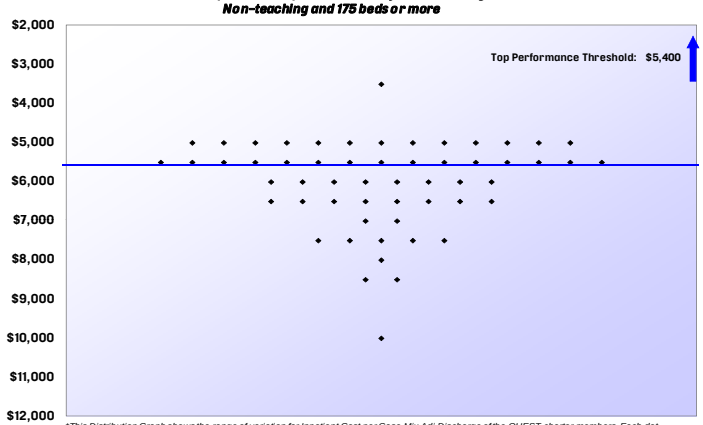


QUEST
HIGH PERFORMING HOSPITALS

QUEST Results:
Distribution Comparison: Cost of Care – NonTeaching

Baseline (3Q 2006 – 2Q 2007)	3Q 2008 - 2Q 2009

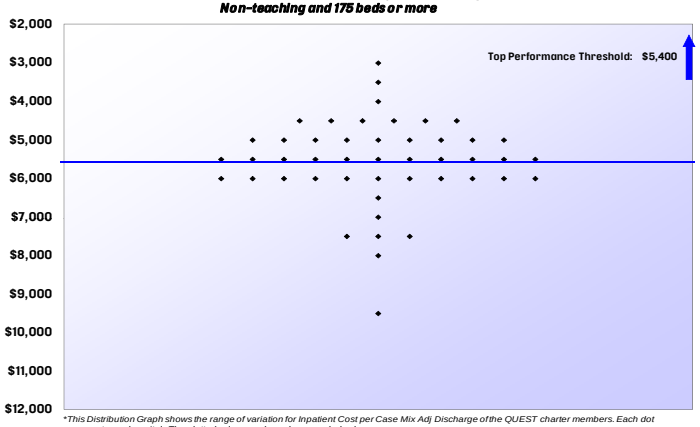
Total Inpatient Cost per Case Mix Adjusted Discharge
Non-teaching and 175 beds or more



*This Distribution Graph shows the range of variation for Inpatient Cost per Case Mix Adj Discharge of the QUEST charter members. Each dot represents one hospital. The plotted values are based on rounded values.

>= 175 Beds

Total Inpatient Cost per Case Mix Adjusted Discharge
Non-teaching and 175 beds or more



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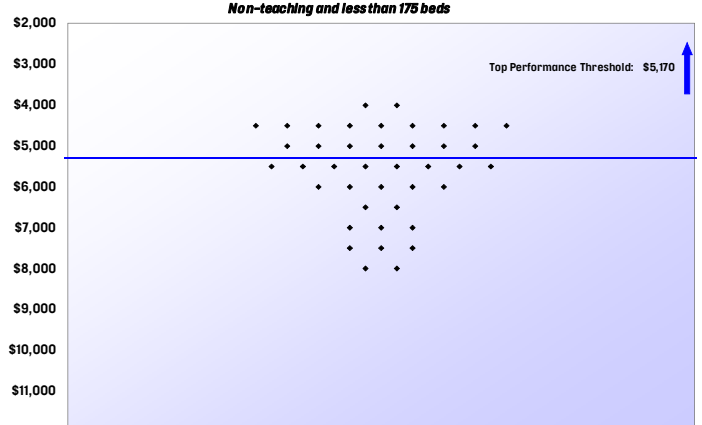
Total Inpatient Cost per Case Mix Adjusted Discharge
Non-teaching and less than 175 beds



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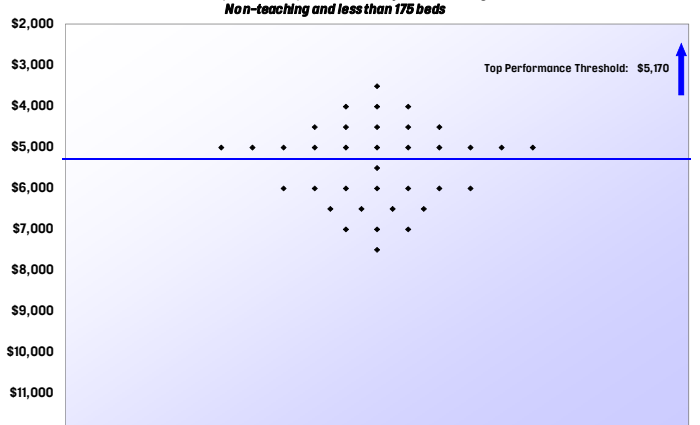
< 175 Beds

Total Inpatient Cost per Case Mix Adjusted Discharge
Non-teaching and less than 175 beds



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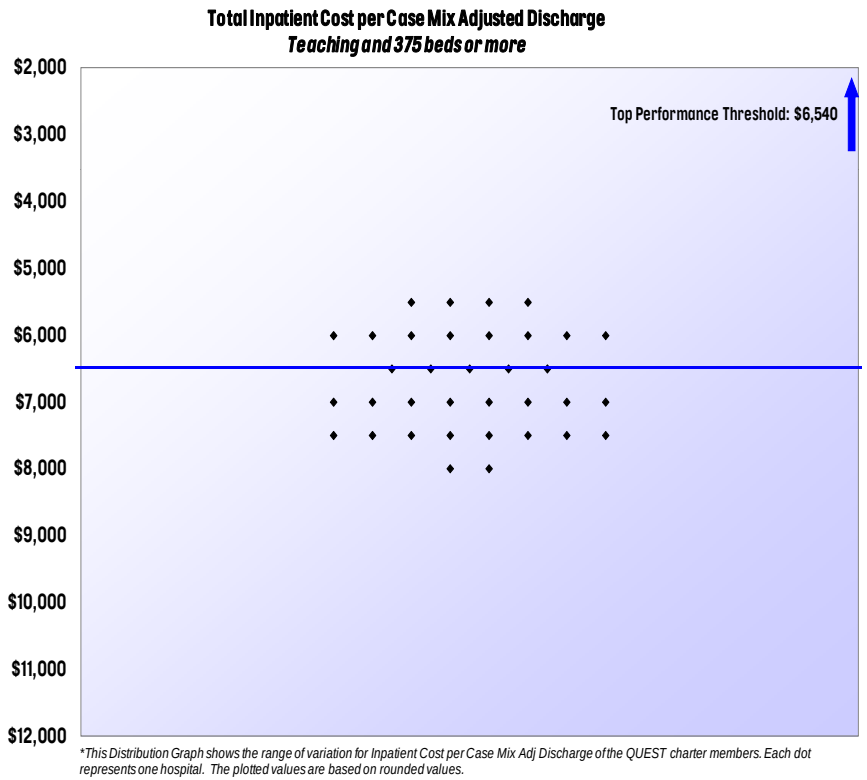
QUEST
HIGH PERFORMING HOSPITALS

QUEST Results:
Distribution Comparison: Cost of Care –Teaching >=375 Beds

Baseline (3Q 2006 – 2Q 2007)



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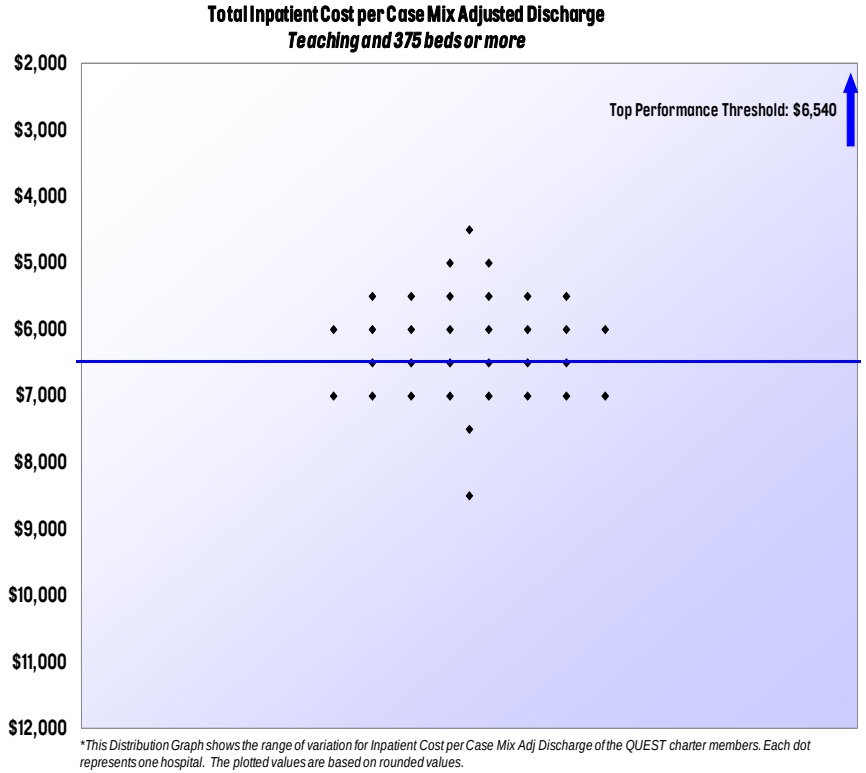
3Q 2008 - 2Q 2009



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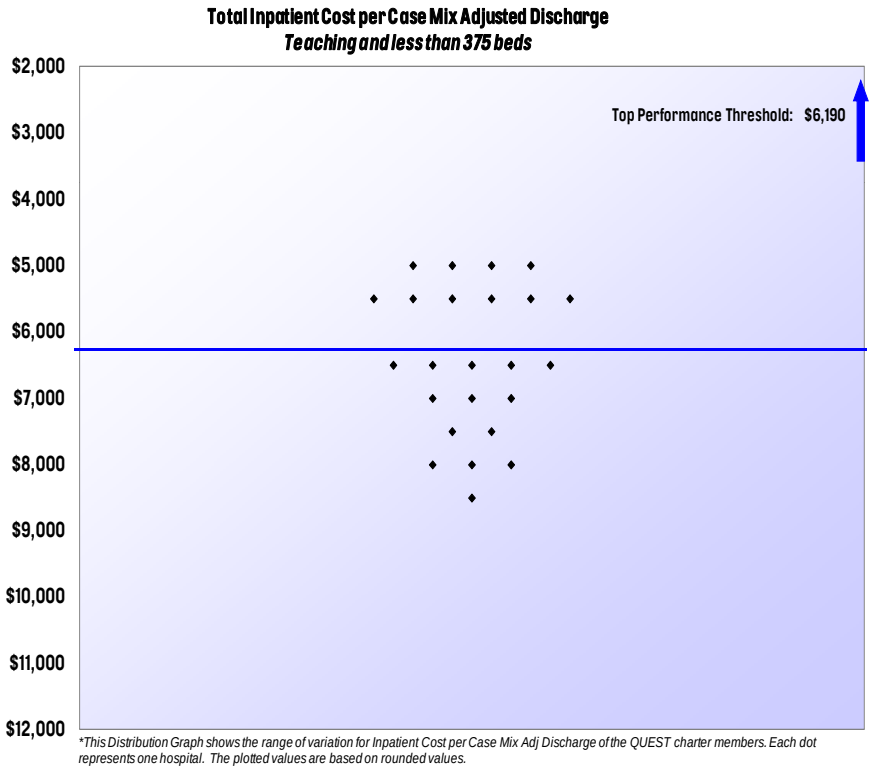
QUEST RESULTS:
Distribution Comparison: Cost of Care – Teaching < 375 Beds

Baseline (3Q 2006 – 2Q 2007)



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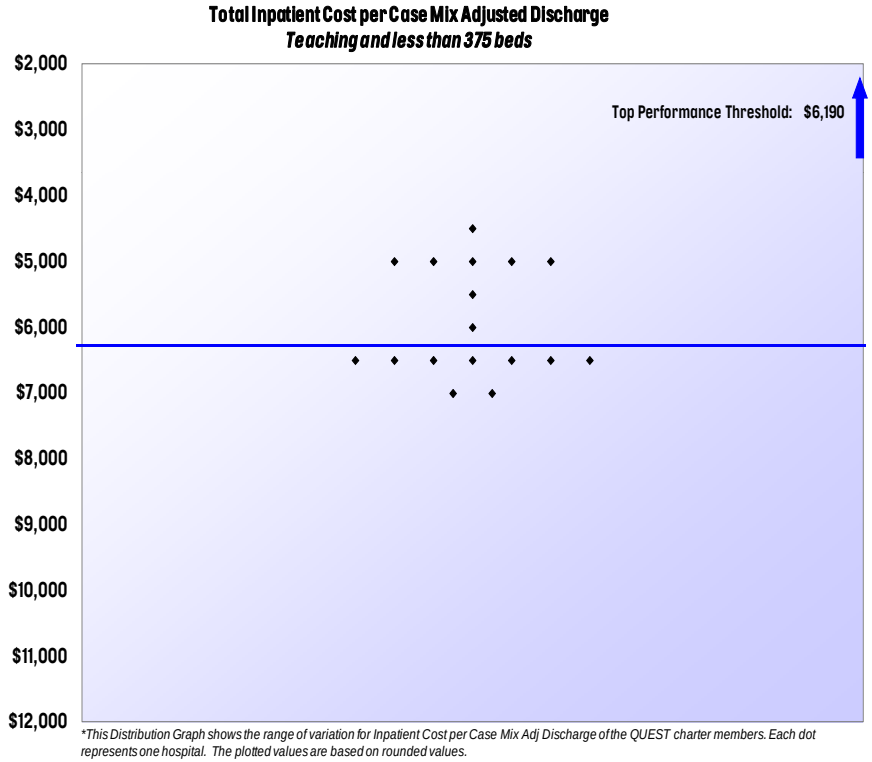
3Q 2008 – 2Q 2009



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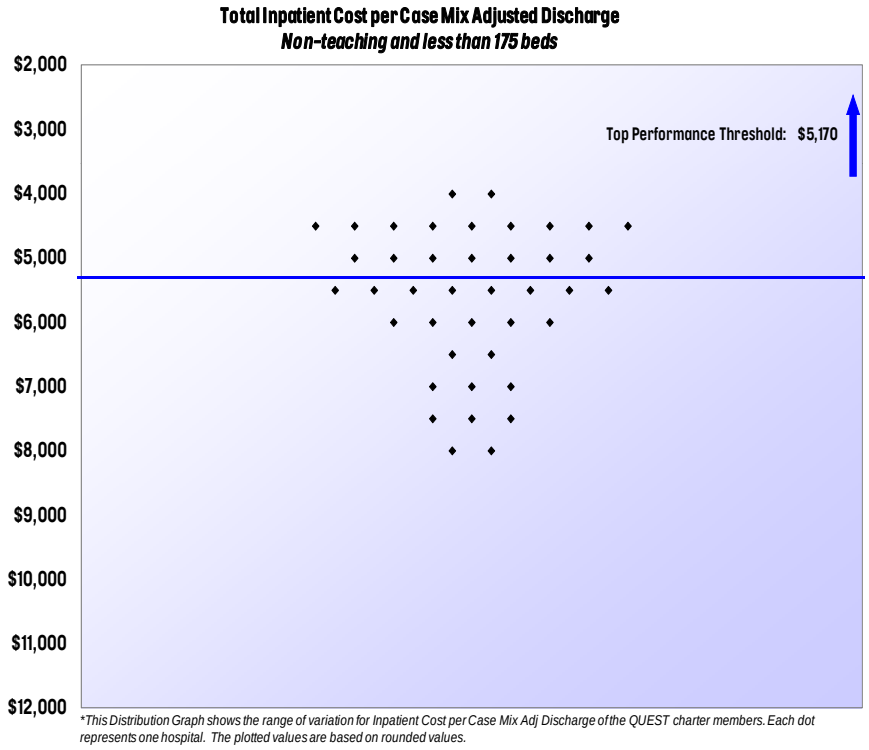
QUEST RESULTS:
Distribution Comparison: Cost – NonTeaching <175 Beds

Baseline (3Q 2006 – 2Q 2007)



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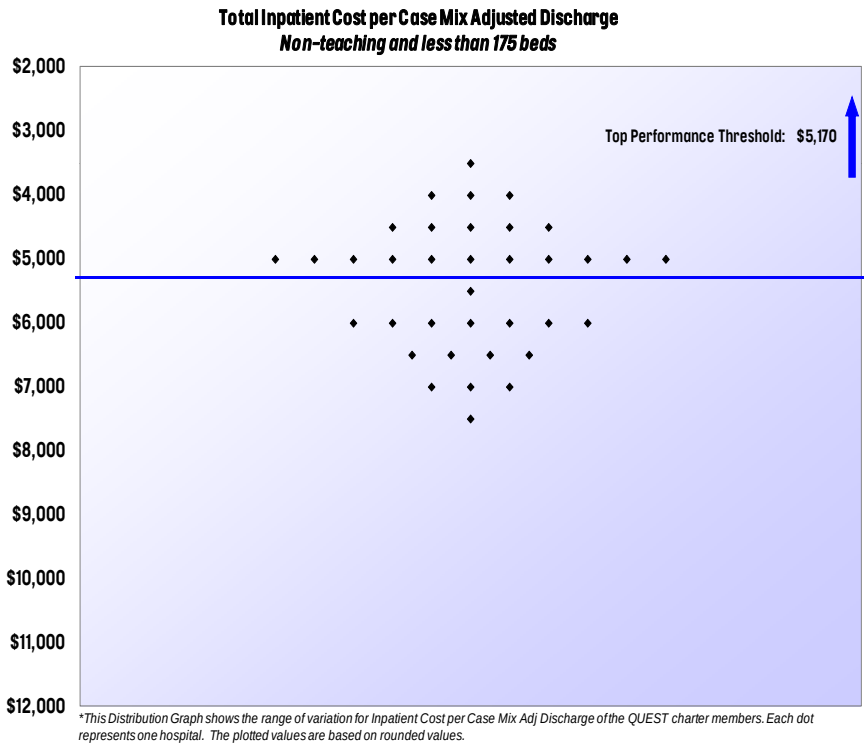

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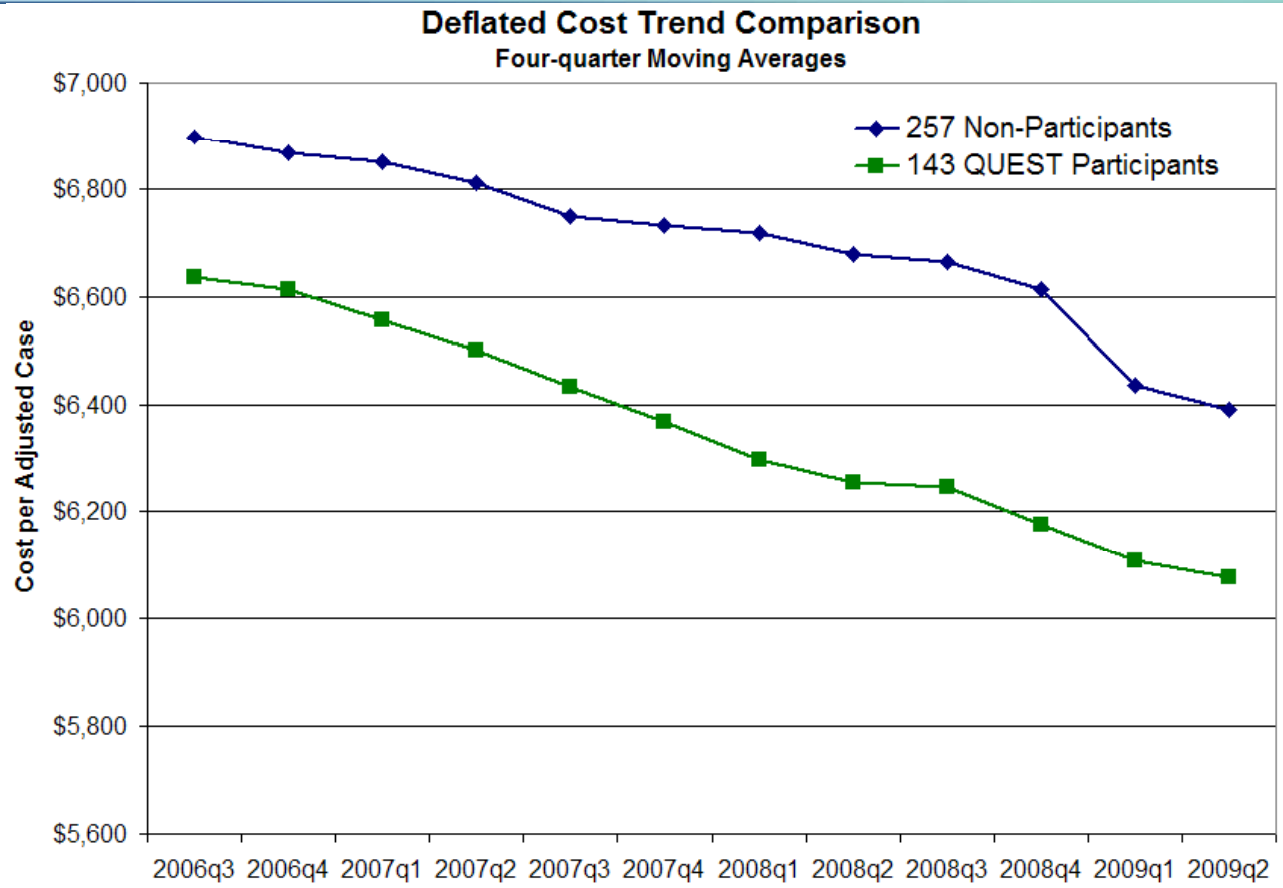
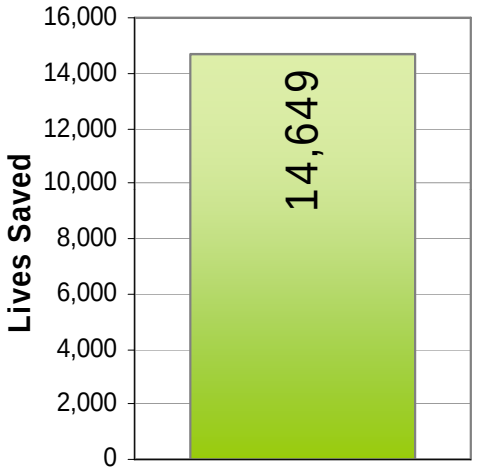
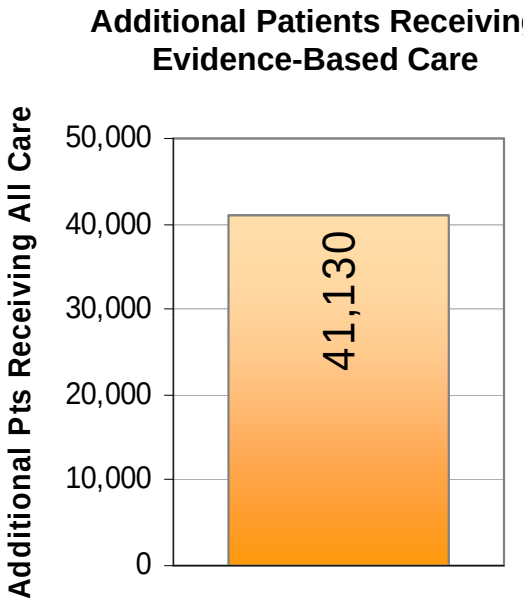
QUEST Participants Compared to Non-Participants: Cost of Care Trends

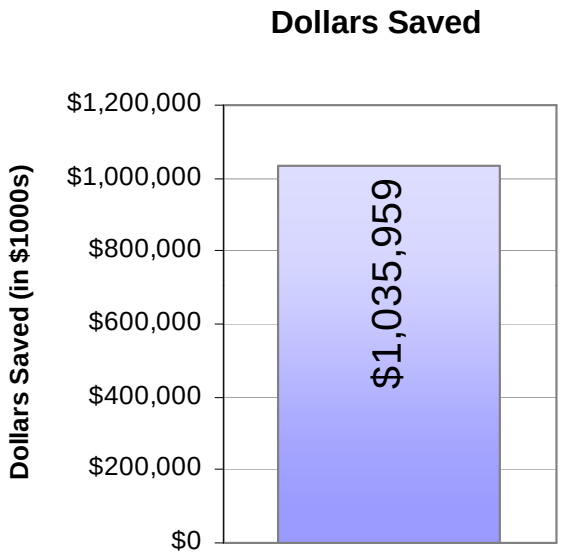


61% of QUEST hospitals in the top performance threshold

Results – Impact on Patients and Hospitals







Consider if you will: If these results were achieved by 157 hospitals, how many lives and dollars would have been saved if all 5,700 + hospitals in this country were able to achieve these improvements?

Domain Updates – Harm and Patient Experience

QUEST Phase I Harm Measures as Collected from Quality Advisor™

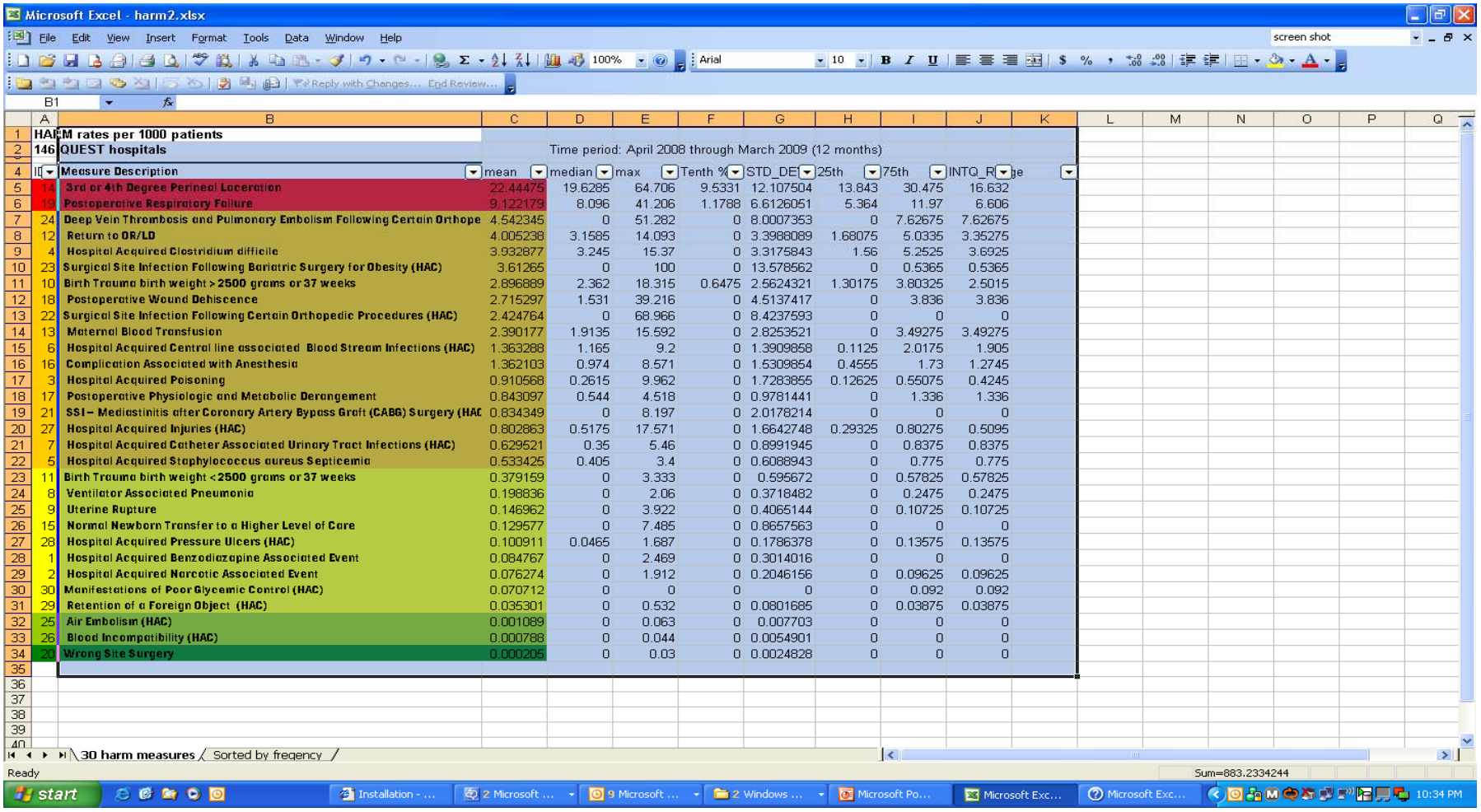
1. Hospital Acquired Benzodiazapine Associated Event
2. Hospital Acquired Narcotic Associated Event
3. Hospital Acquired Poisoning
4. Hospital Acquired Clostridium Difficile*
5. Hospital Acquired Staphylococcus Aureus Septicemia*
6. Hospital Acquired Central line assoc Blood Stream Infections*
7. Hospital Acquired Catheter Associated Urinary Tract Infections*
8. Ventilator Associated Pneumonia*
9. SSI – Mediastinitis after Coronary Artery Bypass Graft (CABG)*
10. Uterine Rupture
11. Birth Trauma birth weight > 2500 grams or 37 weeks
12. Birth Trauma birth weight < 2500 grams or 37 weeks
13. Return to OR/LD
14. Maternal Blood Transfusion
15. 3rd or 4th Degree Perineal Laceration
16. Normal Newborn Transfer to a Higher Level of Care
17. Complication Associated with Anesthesia
18. Postoperative physiologic and metabolic derangement
19. CMS Poor glycemic control
20. Postoperative Wound Dehiscence
21. Postoperative Respiratory Failure
22. Retention of a Foreign Object
23. Air Embolism
24. Blood Incompatibility
25. Hospital Acquired Injuries
26. Hospital Acquired Pressure Ulcers
27. Wrong Site Surgery
28. Surgical site infections –Ortho*
29. Surgical site infections – bariatric*
30. DVT PE following certain Ortho px

*Indicates measures that will also be captured from Safety Surveillor™

Current Status of the Harm Domain

- **Release of Initial Harm Reports (ICD-9 based)**
- **Identification of Top Opportunities for Improvement**
  - **“The Spectrum of Harm”**
  - **Collaborative execution activities developed/ scheduled for the areas of greatest opportunity**
- **Finalization of the Harm Composite Measure**
- **Release of reports during March 2010 with**
  - **NHSN results for appropriate measures**
  - **Composite Index Results**

The “Spectrum of Harm”



Current Status of Patient Experience Domain

- Premier has partnered with Westat in a pilot project to obtain HCAHPS data for 15 hospitals
  - All primary vendors included
  - Assessed
    - Ability to obtain “like” data from all vendors
    - Timeliness of data
    - Granularity of data
    - Ability to develop improvement work around the data
    - Composite scoring
  - Data collection for the pilot completed (October 30)
- Roll-out to entire QUEST membership in process

QUEST – Supporting our Members Through Collaborative Activities

QUEST
HIGH PERFORMING HOSPITALS

PREMIER

Transforming Healthcare Together

Collaboration and Knowledge Transfer
Engaging with QUEST members to improve

National Meetings & Education	• **Face to face meetings - twice per year** • **Twelve month calendar with learning opportunities**
Sprints	• **90 day rapid cycle improvement webinar series to help drive improvement in specific indicators**
Collaboratives	• **6 to 9 month improvement initiatives focused on a specific condition, disease state or process of care**
Resources	• **Clinical Director assigned to each organization** • **QualityAdvisor™ & SafetySurveillor™** • **Performance Improvement Portal**

Upcoming Collaborative Offerings

Sprints

- Catheter Associated UTIs
- VTE Administration (Surgical Patient)
- Cost of Care
- Central line related blood stream infections
- Patient Experience

Collaboratives

- Sepsis
- Eliminating Perinatal Harm
- End of Life/Palliative Care
- Cost of Care

Other Activities

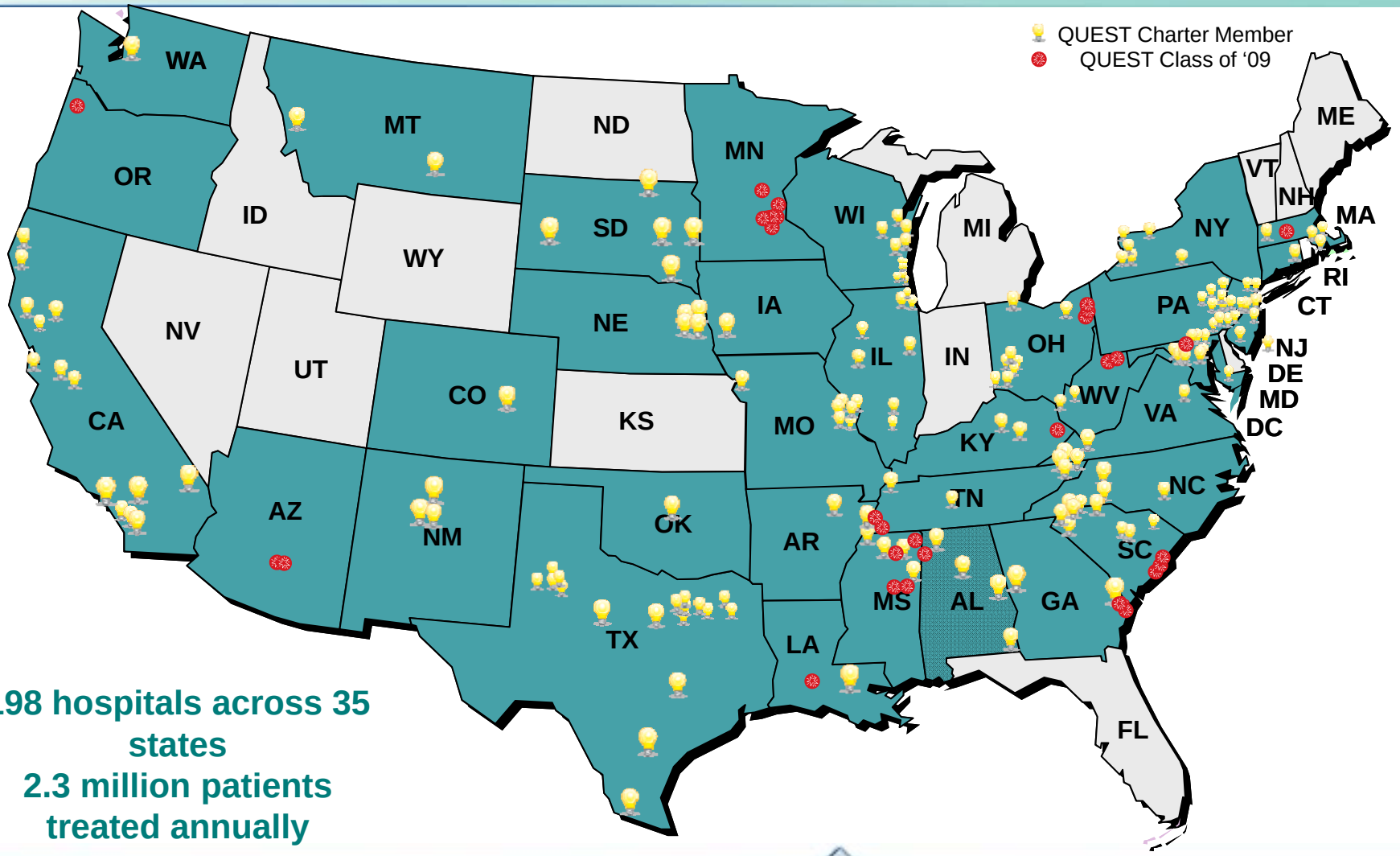
- National meetings
- H2H Readmissions Project
- IHI activities
- Ongoing educational calls

Additional Supports for QUEST Participants

- **Performance Improvement Portal**
  - 24/7 access to more than 14,000 improvement tools
  - Ability to collaborate and learn from others in a virtual environment
  - Specific content and knowledge sharing specific for QUEST members
- **Clinical Directors** assigned to each participating hospital to provide assistance to QUEST hospitals in their improvement efforts

QUEST: Looking to the Future

QUEST Membership – Expanding in 2010



198 hospitals across 35 states
2.3 million patients treated annually

Areas of Future Focus

- Waste
- Readmissions
- Additional Harm Measures (Phase 2)
- Care Coordination/Preparing for Accountable Care Organizations
- Expanded Evidence Based Care Measures
- Increased Focus on Cost Drivers
- Others to be determined based on
  - Data
  - Legislative Activity

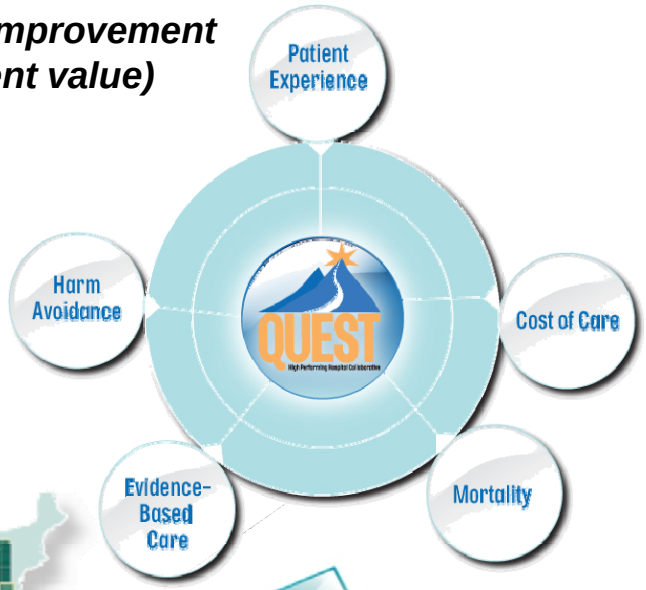
Accountable Care Organizations

The Collaboratives of the (Near) Future

Accountability Collaborative is a Natural Extension for Premier

Population total value

Systemic improvement (inpatient value)



Process Improvement (Inpatient focus)

Governmental Pressures Driving More Accountability

Value-based purchasing

Accountable Care Organizations

Bundled payments

Non-payment for preventable readmissions

Non-payment for infections and HACs

Transparency initiatives

Drive to tack waste, fraud and abuse

Market Pressures Driving More Accountability

Blue Cross introduction of the alternative global contract

Communities building ACOs in response to medical high costs

Local payers talking with large provider organizations because premiums are making it impossible to provide wage increases

Creation of Medical Home Collaborative

Physician organizations moving to become ACOs

Employers contracting with specific providers outside their communities

Insurance regulators refusing premium or rate increases

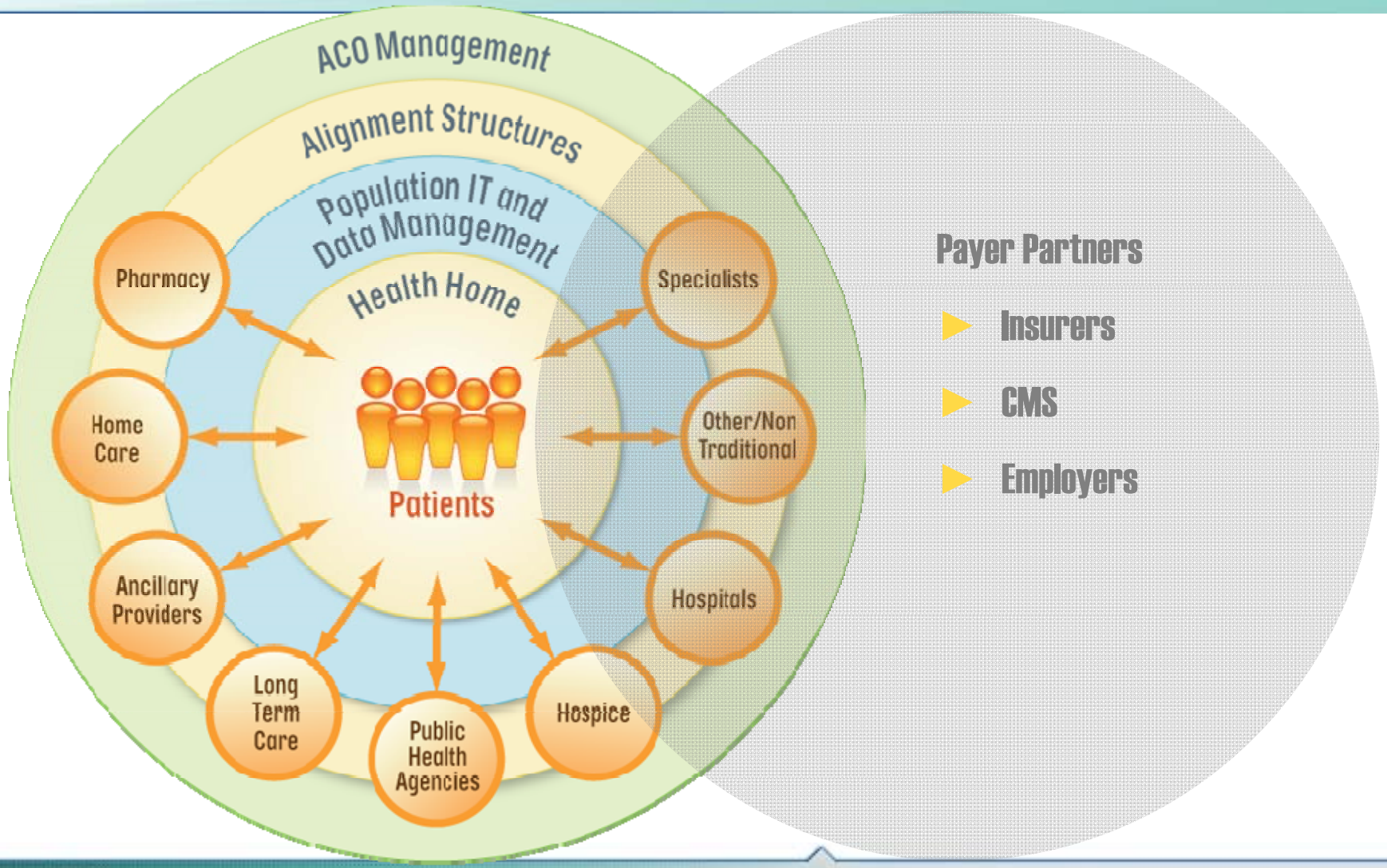
Many Flavors of Accountability

- Single service → Bundled payment for acute care services
- Disease specific → P4P for quality outcomes for diabetics
- Service oriented → Health home payments for service standards
- Segment by illness → Chronic disease patients in CMS demo
- Total population accountability → Accountable Care Organizations

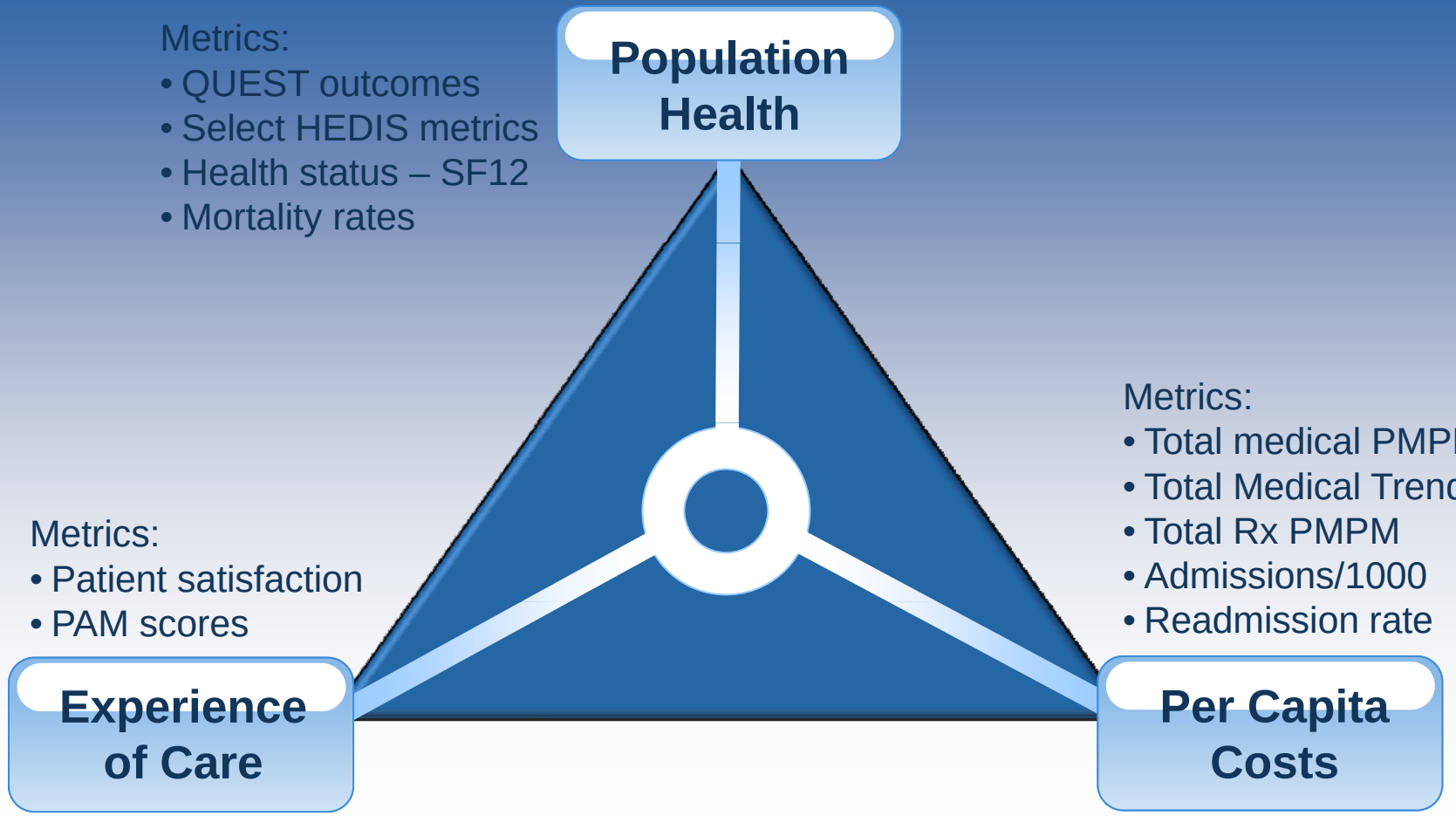
ACO Model: Six Core Components

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

Payer Partnerships are the Seventh Core Component



Definition of Success: Improving Triple Aim™ Population Outcomes



The term triple aim is a trademark of the Institute for Healthcare Improvement

Two Collaborative Tracks Meet the Needs of Both

ACO Implementation Collaborative

- Early ACO implementation
- Pursue CMS/national payer contracts
- Build out core ACO capabilities
- Tool kits, best practices
- Benchmark against peers
- Accelerate learning and population management capabilities
- Prominent national leadership

ACO Readiness Collaborative

- Explore accountability initiatives
- Maximum learning and shared lessons
- Stay abreast of ACO development
- Opportunity to access collaborative for limited tool kits
- Gap analysis to pinpoint focus areas
- Learn about population management
- Preparation for local leadership as ACO moves forward

For Additional Information:

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(817) 800-6504

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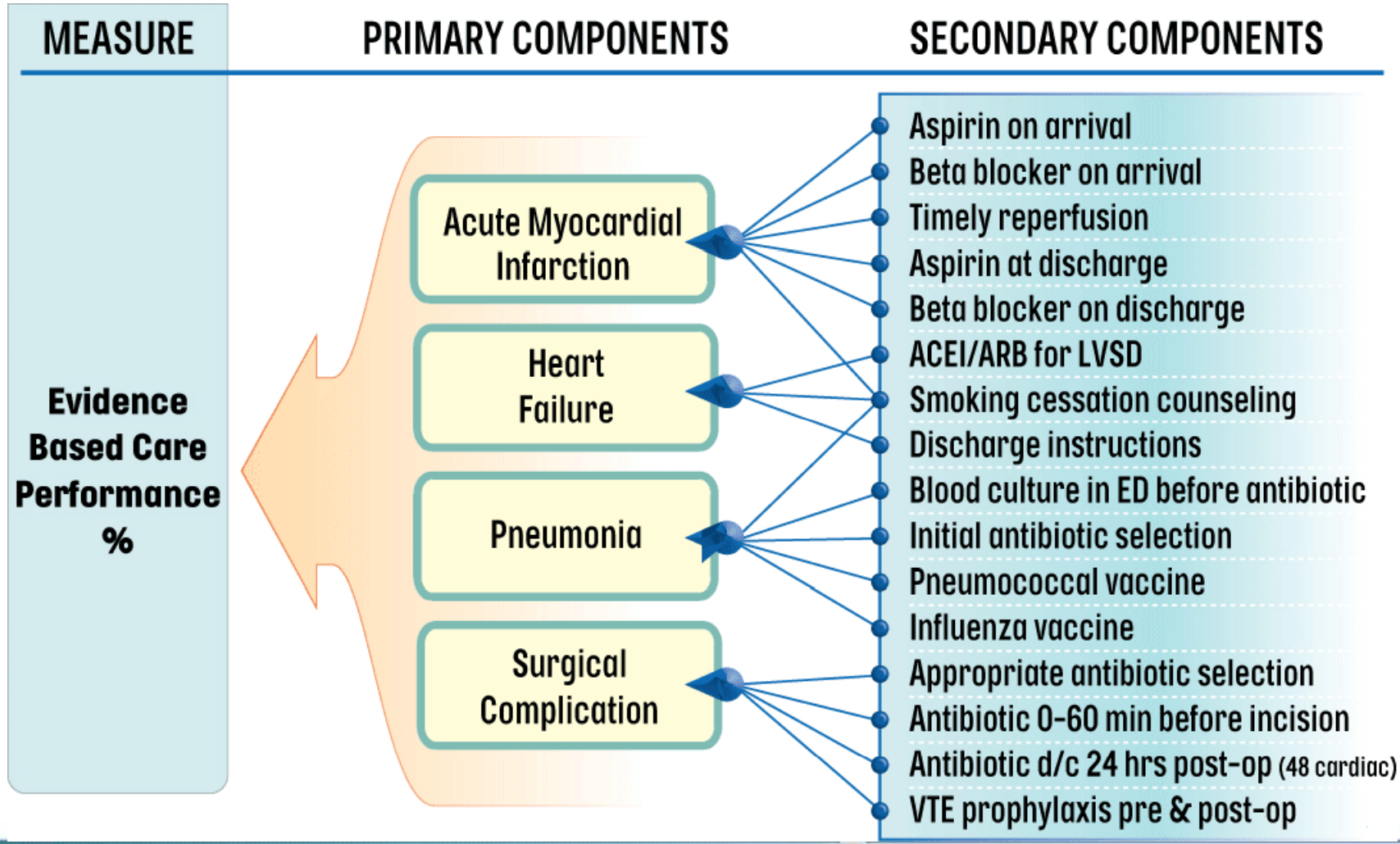
Appendix

QUEST Domains and Sample Reports

Our Evidence Based Care Performance Measure: "All or Nothing Score"



QUEST CHARTER MEMBER PERFORMANCE REPORT
EVIDENCED BASED CARE DRILL DOWN REPORT: 2008Q3 Quarter to Date

To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial - Anytown, USA

Report Period: Jul08-Sep08 (7/1/2008-9/30/2008) **Report Generated: 6/8/2009**

Evidence-Based Care

Top Performance Threshold for Overall Evidence-Based Care Rate: 84%

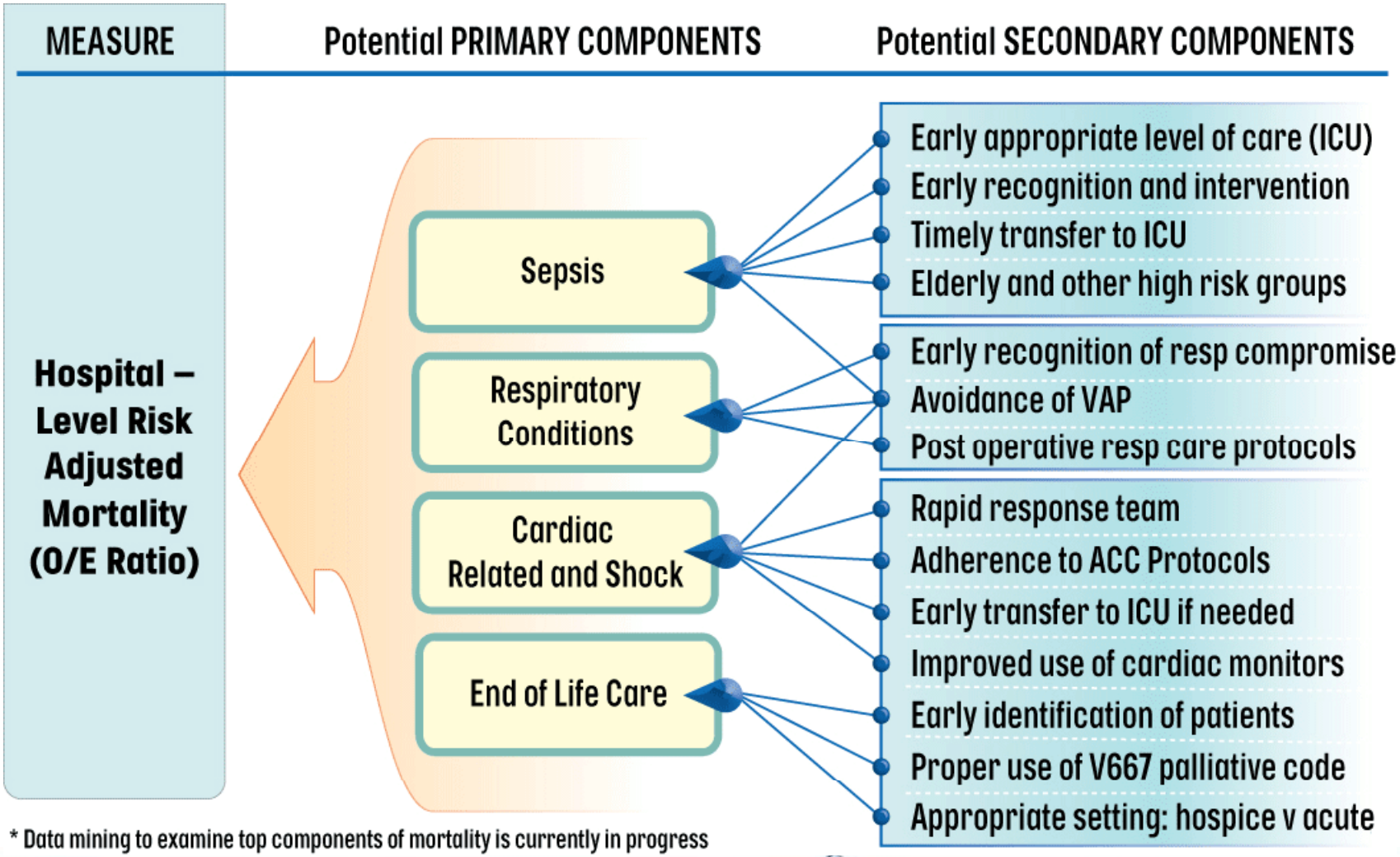
Measure Results:	Hospital Evidence-Based Care Rate	Percentile					Measure Numerator	Measure Denominator	Total Eligible Discharges
		95th	90th	75th	50th	25th			
QUEST All-or-None Composite Score	**85%**	**97%**	**95%**	**92%**	**89%**	**84%**	**349**	**353**	**0**
Acute Myocardial Infarction									
AMI All-or-None Composite Score	**100%**	**100%**	**100%**	**99%**	**95%**	**90%**	**331**	**341**	**0**
AMI-1: Aspirin at arrival	**100%**	100%	100%	100%	100%	98%	288	301	
AMI-2: Aspirin prescribed at discharge	**100%**	100%	100%	100%	100%	98%	133	141	
AMI-3: ACEI or ARB for L VSD	**100%**	100%	100%	100%	100%	96%	11	11	
AMI-4: Adult smoking cessation advice/counseling	**100%**	100%	100%	100%	100%	100%	9	9	
AMI-5: Beta-blocker prescribed at discharge	**100%**	100%	100%	100%	100%	98%	5	5	
AMI-6: Beta-blocker at arrival	**100%**	100%	100%	100%	100%	95%	2	2	
AMI-7a: Fibrinolytic agent within 30 min of hospital arrival	**0%**	100%			33%		2	2	
AMI-8a: Primary PCI within 90 min of hospital arrival	**100%**	100%	100%	100%	88%	75%	5	5	
Heart Failure									
HF All-or-None Composite Score	**86%**	**100%**	**100%**	**96%**	**90%**	**82%**	**7**	**7**	**0**
HF-1: Discharge Instructions		100%	100%	97%	90%	83%			
HF-3: ACEI or ARB for LVSD		100%	100%	100%	100%	93%			
HF-4: Adult smoking cessation advice/counseling	**100%**	100%	100%	100%	100%	100%	42	42	
Pneumonia									
PN All-or-None Composite Score	**100%**	**100%**	**100%**	**96%**	**92%**	**85%**	**39**	**39**	**0**
PN-2: Pneumococcal vaccination	**100%**	100%	100%	100%	95%	88%	11	11	
PN-3b: BC performed in the ED prior to Initial Abx Rc'd in hospital	**100%**	100%	100%	100%	98%	94%	16	16	
PN-4: Adult smoking cessation advice/counseling	**100%**	100%	100%	80%	86%		36	38	
PN-6: Initial abx selection for CAP immunocompetent pts	**100%**	100%	100%	100%	94%	88%	23	24	
PN-7: Influenza Vaccination									
Surgical Care Infection Prevention									
SCIP-INF All-or-None Composite Score	**81%**	**97%**	**95%**	**92%**	**86%**	**79%**	**9**	**9**	**0**
SCIP-INF-1a: Prophylactic abx rec'd w/i 1 hr prior to surgical incision	**88%**	100%	100%	99%	97%	93%	10	10	
SCIP-INF-2a: Prophylactic abx selection for surgical pts		100%	100%	99%	98%	96%			
SCIP-INF-3a: Prophylactic abx discontinued within 24 hours after surgery end time/48 hours for CABG or Other Cardiac Surgery	**89%**	100%	99%	97%	94%	90%	44	50	
SCIP-VTE-2: Surgery pts who rec'd appropriate VTE prophylaxis w/i 24 hours prior to surgery up to 24 hours after surgery end time	**98%**	100%	99%	97%	93%	88%	33	33	

Measure definitions on Report Definitions Page

Top Performance Thresholds are based on historical data (7-1-2006 to 6-30-2007) for those hospitals fully in as of 12/31/2007. *There are 166 hospitals in the QUEST program that represent 158 data reporting entities. These Thresholds are FINAL and will represent the goal of QUEST for three years. There are no top performance thresholds for subsets of the measures - AMI, PNE, etc. Total discharges refer to total discharges on which the metric is based and may differ slightly among metrics.

For questions about this report, or any QUEST related topic, contact your Premier QUEST Sponsor: BJ Phansiri: BJ_Phansiri@premierinc.com

Our Mortality Measure and Potential Components



* Data mining to examine top components of mortality is currently in progress

To achieve unprecedented results in quality, safety, and efficiency

PMR - Premier Memorial (Anytown, USA)

Mortality Detail Report

Entity Code	PMR
Entity Name	Premier Memorial
Entity City	Anytown
Entity State	USA
Grouping Type	DRG
Time Period Description	Apr 2008 (4/1/2008-4/30/2008)
Date Generated	7/23/2008
Premier Quest Sponsor	Roxanne Rowe: roxanne_rowe@premierinc.com

Periods	Baseline	00810120081	00810220081	00810320081	00820420082(	P5	P6	P7	P8	P9
Period Name	Jul06-Jun07	Jan 2008	Feb 2008	Mar 2008	Apr 2008					

Aggregate Data	Jul06-Jun07	Jan 2008	Feb 2008	Mar 2008	Apr 2008					
Total Cases (denominator)	11918	1045	1094	1153	1031					
Observed Mortality	1.5%	1.2%	1.4%	0.9%	1.1%					
Expected Rate	1.8%	2.6%	2.1%	1.6%	1.7%					
Mortality O/E Ratio - by Period	0.82	0.48	0.67	0.54	0.64					
Moratlity O/E Ratio - YTD	0.82	0.48	0.56	0.56	0.57					
Mortality O/E Target	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82
Deviation from Expected	(0.3)%	(1.4)%	(0.7)%	(0.7)%	(0.6)%					
Deaths in Excess of Predicted	(38)	(14)	(7)	(9)	(6)					
Significance	**	**	**	**	*					

Business Line	Cases	Observed Mortality	Expected Mortality	Deviation from Expected	Deaths in Excess of Predicted	Signif	O/E Ratio
NEUROLOGY (9)	36	5.6%	1.7%	3.8%	1	**	3.2
MEDICAL ONCOLOGY (10)	15	13.3%	7.7%	5.6%	1	**	1.7

Diagnosis Grouping	Cases	Observed Mortality	Expected Mortality	Deviation from Expected	Deaths in Excess of Predicted	Signif	O/E Ratio
RENAL FAILURE WITH MCC (682)	1	100.0%	6.6%	93.4%	1	**	15.2
AMI, EXPIRED WITH CC (284)	1	100.0%	7.5%	92.5%	1	**	13.3
INTRACRAN HEMORRH OR CEREB	2	50.0%	7.7%	42.3%	1	**	6.5
TRAUMATIC STUPOR & COMA >1 H	1	100.0%	15.5%	84.5%	1	**	6.5
DIGESTIVE MALIGNANCY WITH MC	1	100.0%	17.5%	82.5%	1	**	5.7
MAJOR SMALL & LARGE BOWEL PR	3	33.3%	7.1%	26.3%	1	**	4.7
RESP INFECTIONS & INFLAMMATIO	4	25.0%	7.2%	17.8%	1	*	3.5
INTERSTITIAL LUNG DISEASE WITH	2	50.0%	17.4%	32.6%	1	**	2.9

QUEST CHARTER MEMBER PERFORMANCE REPORT
MORTALITY DRILL DOWN REPORT

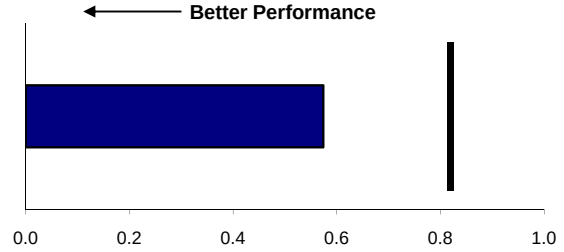
To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial - Anytown, USA

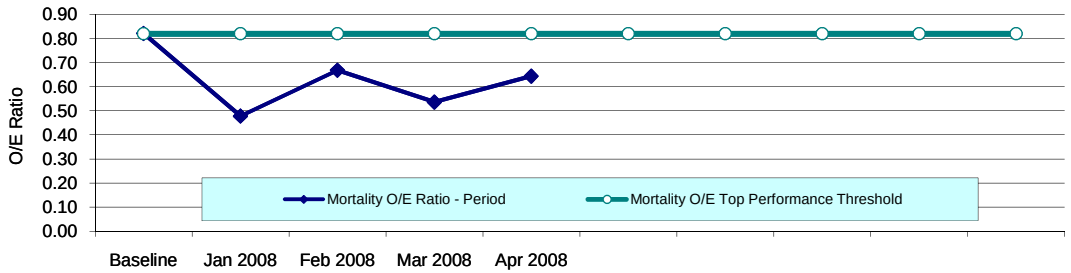
Report Period: Apr 2008 (4/1/2008-4/30/2008) **Report Generated: 7/23/2008**

Primary Measure: Observed/Expected Ratio (Top Performance Threshold = 0.82, based on top quartile of July 1, 2006-June 30 2007 Baseline period)

Year-To-Date Mortality O/E Ratio



O/E Ratio Trend



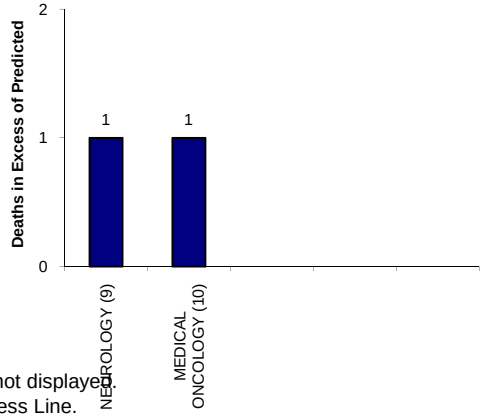
Charter Member Entity-Wide Performance	Baseline	Jan 2008	Feb 2008	Mar 2008	Apr 2008					
Total Cases (denominator)	11918	1045	1094	1153	1031					
Observed Mortality Rate	1.5%	1.2%	1.4%	0.9%	1.1%					
Expected Mortality Rate	1.8%	2.6%	2.1%	1.6%	1.7%					
Mortality O/E Ratio - Period	**0.82**	**0.48**	**0.67**	**0.54**	**0.64**					
Mortality O/E Ratio - YTD	**0.82**	**0.48**	**0.56**	**0.56**	**0.57**					
Deviation from Expected Mortality: (O - E)	-1.7% **	-2.6% **	-1.3% **	-1.3% **	-1.4% *					
Net Deaths in Excess of Predicted: (O - E) * Cases	(38)	(14)	(7)	(9)	(6)					

* Statistically Significant at 75% Confidence Level ** Statistically Significant at 95% Confidence Level

Note: Net deaths in excess of expected includes both positive (if worse than expected) and negative (if better than expected) numbers and therefore does NOT represent the sum of all excess deaths occurring at the Business line or APRDRG levels. Risk adjustment methodology is based on the CareScience Risk Adjustment methodology.

Top 10 Mortality Opportunities by Business Line **Reporting Period: Apr 2008 (4/1/2008-4/30/2008)**

Business Line (DRG/MSDRG)	Cases	Observed Mortality	Expected Mortality	Deviation from Expected (O - E)	O/E Ratio (O/E)	Deaths in Excess of Predicted (O - E) * Cases
NEUROLOGY (9)	36	5.6%	1.7%	3.8% **	3.23	1
MEDICAL ONCOLOGY (10)	15	13.3%	7.7%	5.6% **	1.73	1



* Statistically Significant at 75% Confidence Level ** Statistically Significant at 95% Confidence Level Opportunities not statistically significant are not displayed.

Note: Only positive opportunities are shown which may result in fewer than 10 Business Lines in the above list, or none if no opportunities exist by Business Line. Risk adjustment methodology is based on the CareScience Risk Adjustment methodology.

QUEST CHARTER MEMBER PERFORMANCE REPORT
MORTALITY DRILL DOWN REPORT

To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial - Anytown, USA

Report Period: Apr 2008 (4/1/2008-4/30/2008) **Report Generated: 7/23/2008**

Primary Measure: Observed/Expected Ratio (Top Performance Threshold = 0.82, based on top quartile of July 1, 2006-June 30 2007 Baseline period)

Top 20 Mortality Opportunities by Disease Group **Reporting Period: Apr 2008 (4/1/2008-4/30/2008)**

Diagnosis Grouping(DRG/MSDRG)	Cases	Observed Mortality	Expected Mortality	Deviation from Expected (O - E)	O/E Ratio (O/E)	Deaths in Excess of Predicted (O - E) * Cases
RENAL FAILURE WITH MCC (682)	1	100.0%	6.6%	93.4% **	15.18	1
AMI, EXPIRED WITH CC (284)	1	100.0%	7.5%	92.5% **	13.27	1
INTRACRAN HEMORRH OR CEREB INFARCT W MCC (64)	2	50.0%	7.7%	42.3% **	6.51	1
TRAUMATIC STUPOR & COMA >1 HOUR W CC (83)	1	100.0%	15.5%	84.5% **	6.45	1
DIGESTIVE MALIGNANCY WITH MCC (374)	1	100.0%	17.5%	82.5% **	5.73	1
MAJOR SMALL & LARGE BOWEL PROC W CC (330)	3	33.3%	7.1%	26.3% **	4.73	1
RESP INFECTIONS & INFLAMMATIONS W CC (178)	4	25.0%	7.2%	17.8% *	3.47	1
INTERSTITIAL LUNG DISEASE WITH MCC (196)	2	50.0%	17.4%	32.6% **	2.88	1

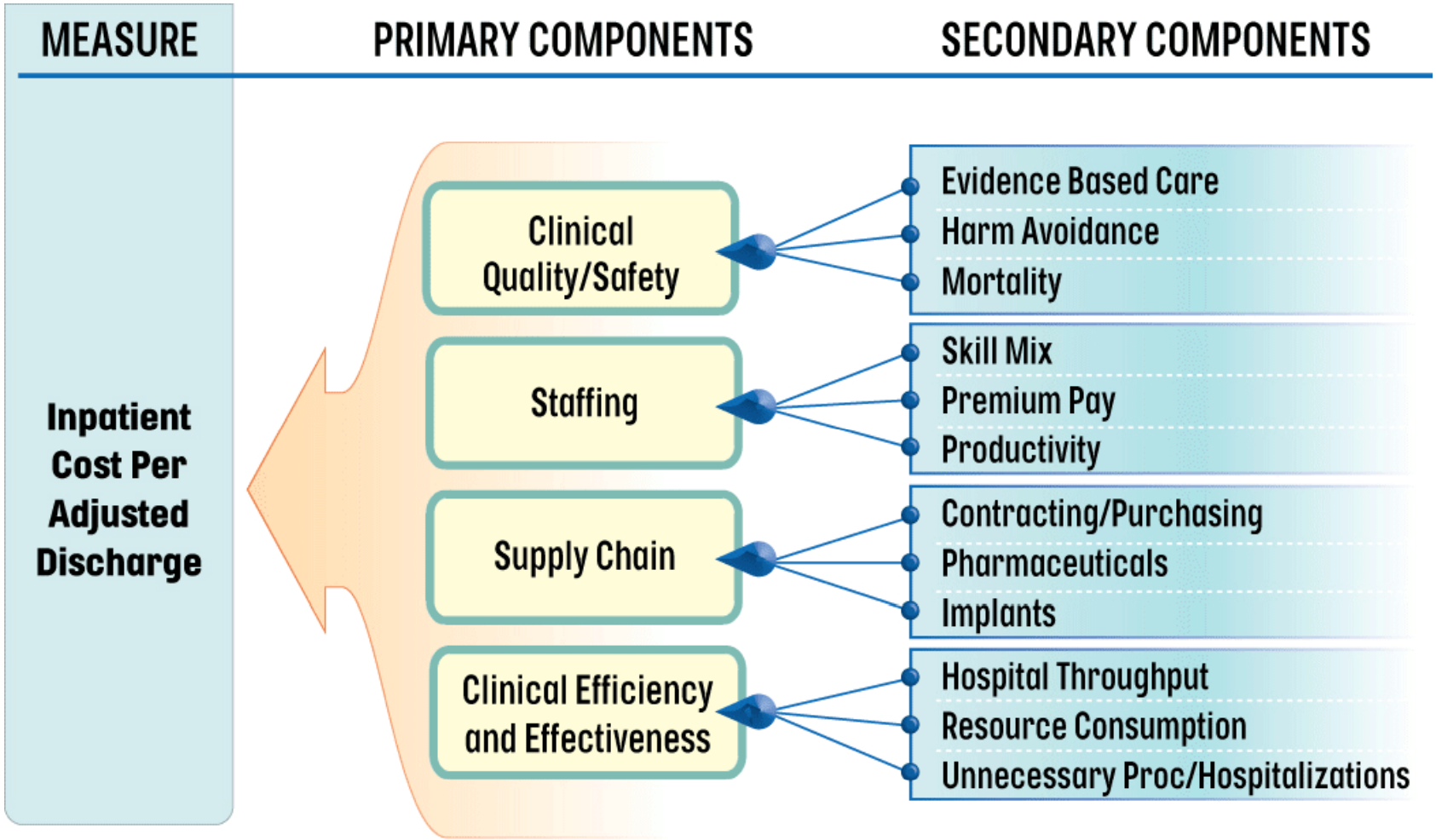
* Statistically Significant at 75% Confidence Level ** Statistically Significant at 95% Confidence Level Opportunities not statistically significant are not displayed.

Note: Only positive opportunities are shown which may result in fewer than 20 Diagnosis Groups in the above list, or none if no opportunities exist by Diagnosis Grouping. Risk adjustment methodology is based on the CareScience Risk Adjustment methodology.

Top Performance Thresholds are based on historical data (7-1-2006 to 6-30-2007, the "Baseline") for those hospitals fully in as of 12/31/2007. *There are 170 hospitals in the QUEST program that represent 162 data reporting entities. These Thresholds are FINAL and will represent the goal of QUEST for three years. Total discharges refer to total discharges on which the metric is based and may differ slightly among metrics.

For questions about this report, or any QUEST related topic, contact your Premier QUEST Sponsor: Roxanne Rowe: roxanne_rowe@premierinc.com

Our Cost of Care Measure and Potential Components



QUEST CHARTER MEMBER PERFORMANCE REPORT
PRELIMINARY COST OF CARE REPORT 2009Q1

To achieve unprecedented results in quality, safety, and efficiency

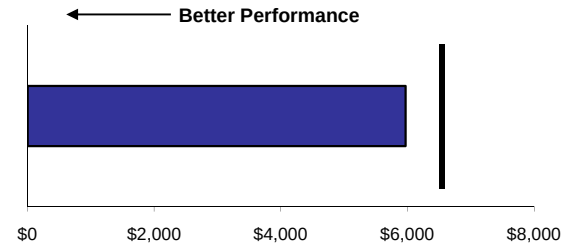
Premier Memorial Medical Center - Anytown, US

Report Period: Jan09-Mar09 (1/1/2009-3/31/2009) **Report Generated: 7/29/2009**

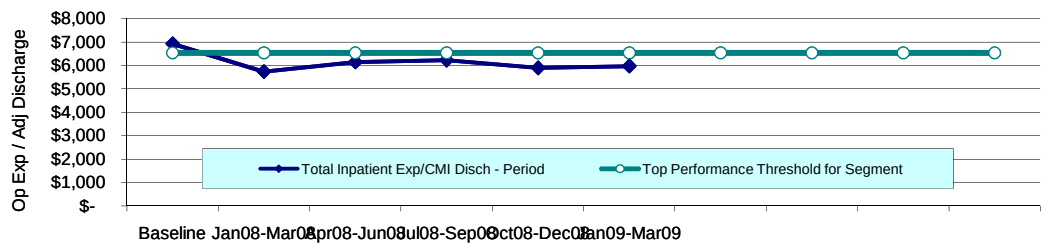
Cost of Care Primary Measure: Total Wage-Adjusted Inpatient Operating Expense per CMI Adjusted Discharge (Inflation Adjusted)

Hospital Segment: Teaching >= 375 Beds (Top Performance Threshold: $6540)

Year-To-Date Total Inpatient Op Exp/CMI-Discharge



Total Inpatient Operating Expense per CMI-Discharge: Trend



Note: The Primary Measure this quarter is more than a 10% change from the Baseline; please review submitted elements.

Charter Member Entity-Wide Performance	Baseline	Jan08-Mar08	Apr08-Jun08	Jul08-Sep08	Oct08-Dec08	Jan09-Mar09				
Total Discharges	23333	6381	5893	5832	5834	5909				
Total Operating Expense ($1000s)[1]	$344,328	$86,121	$88,472	$90,271	$89,901	$87,321				
Case Mix Index (CMI)	1.48	1.56	1.56	1.56	1.60	1.49				
Case Mix Methodology[2]	Baseline	Calculated	Calculated	Calculated	Calculated	Self-Rpt (OA)				
Wage Index (WI)	87.08%	87.08%	87.08%	87.08%	85.88%	85.88%				
Labor Cost Ratio (LCR)	47.00%	47.00%	47.00%	47.00%	43.00%	43.00%				
Wage Adjustment Factor (WAF: LCR/WI + 1 - LCR)	1.070	1.070	1.070	1.070	1.070	1.070				
Gross Patient Revenue - $1000s (GPR)	$1,226,487	$366,099	$342,767	$341,428	$365,765	$367,695				
Gross Inpatient Revenue - $1000s (GIR)	$803,794	$248,911	$226,628	$223,654	$237,921	$238,992				
Other Operating Revenue - $1000s (OOR)	$9,186	$2,249	$2,679	$1,939	$2,234	$2,480				
Inpatient Adjustment Factor (IAF: GIR/(GPR+OOR))	0.650	0.680	0.660	0.650	0.650	0.650				
Inflation Factor (IF)	1.000	0.916	0.909	0.897	0.886	0.871				
Total Inpatient Exp/CMI Disch - Period[3]	**$6,925**	**$5,730**	**$6,140**	**$6,220**	**$5,890**	**$5,970**				
Opportunity to Top Performance Threshold - Period	$13,338,141	$0	$0	$0	$0	$0				
Total Inpatient Exp/CMI Disch - YTD[3]	**$6,925**	**$5,730**	**$5,930**	**$6,030**	**$5,990**	**$5,970**				

Please note that "Total Inpatient Exp/CMI Disch" results are rounded to the nearest $10

1. Total Operating Expense excludes Bad Debt, Interest Expense, Amortization, and Depreciation; see Cost of Care Framework for full definition
2. CMI may be pulled from one of four sources depending on availability, prioritized in this order: 1) calculated, final MSDRG from the quarter, 2) self-reported from Cost of Care submission, 3) calculated from clinical data submission from the same quarter in the previous year, and 4) the CMI utilized for the baseline time period. Only calculated, final MSDRG from the quarter is considered "final" results.
3. QUEST Primary Measure Calculation: (WAF x Total Operating Expense x IAF) / (CMI x Discharges) x IF
4. Data on expenses and revenues are reported directly from the individual hospital and have not been verified nor subjected to audit.

Top Performance Thresholds are based on historical data (7-1-2006 to 6-30-2007) for those hospitals fully in as of 12/31/2007. *There are currently 166 hospitals in the QUEST program that represent 158 reporting entities. These Thresholds are FINAL and will represent the goal of QUEST for three years. Total discharges refer to total discharges on which the metric is based and may differ slightly among metrics.

For questions about this report, or any QUEST related topic, contact your Premier QUEST Sponsor: Richard Brandon: richard_brandon@premierinc.com

QUEST CHARTER MEMBER PERFORMANCE REPORT
PRELIMINARY COST OF CARE REPORT 2009Q1

To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial Medical Center - Anytown, US

Report Period: Jan09-Mar09 (1/1/2009-3/31/2009) **Report Generated: 7/29/2009**

Cost of Care Primary Measure: Total Wage-Adjusted Inpatient Operating Expense per CMI Adjusted Discharge (Inflation Adjusted)

Submitted Data Elements - Current Quarter

Data Element	ID	Value Submitted
Self-Reported Case Mix Index - Total	900	1.49
Discharges - Total	400	5,909
Gross Patient Revenue	1000	$373,233,996
Gross Inpatient Revenue	1010	$240,488,636
Gross Patient Revenue from Hospital Employed Physicians	1027	$5,539,062
Gross Inpatient Revenue from Hospital Employed Physicians	1029	$1,497,057
Other Operating Revenue	1040	$2,480,196
Operating Investment Income	1045	$0
Total Operating Expense	2000	$117,577,343
Labor Expense	2010	$34,572,314
Hospital Employed Physicians Expense	2040	$2,579,515
Current Depreciation Expense	2100	$6,552,132
Amortization	2150	$72,675
Interest Expense	2200	$1,937,862
Bad Debt Expense	2300	$19,114,624

Calculations

Total Operating Expense (TOE) = [2000]-[2300]-[2200]-[2150]-[2100]-[2040]	2000	2300	2200	2150	2100	2040	Total
	$117,577,343	$19,114,624	$1,937,862	$72,675	$6,552,132	$2,579,515	$87,320,535

Gross Patient Revenue (GPR) = [1000]-[1027]	1000	1027	Total
	$373,233,996	$5,539,062	$367,694,934

Gross Inpatient Revenue (GIR) = [1010]-[1029]	1010	1029	Total
	$240,488,636	$1,497,057	$238,991,579

Facility Comparative Performance Report: Cost of Care

OperationsAdvisor™

Premier Memorial Medical Center - Anytown, US

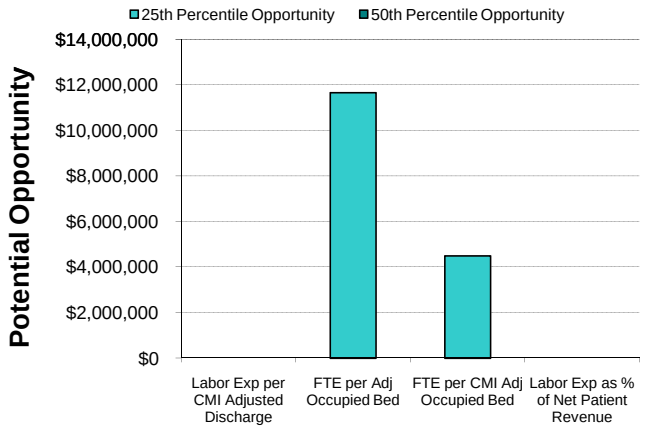
2009Q1

Core Opportunities by Expense Category

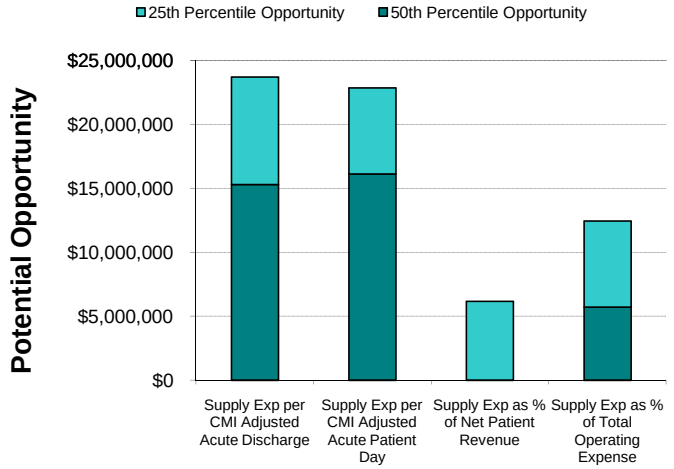
Measure	My Facility	My Quartile	25th Ptile	50th Ptile	75th Ptile	Annualized $$ Opp to 50th Ptile	Annualized $$ Opp to 25th Ptile
Peer Group: QUEST Segment Teaching >= 375 Beds						**Data elements on this report are self-reported and have not been verified or audited**	
Total Expense Indicators							
Total Inpatient Expense per CMI-Discharge (QUEST)	$5,970	N/A	N/A	$6,540	N/A	$0	N/A
Total Hospital Expense per CMI Adj Discharge	$8,658	3	$7,084	$8,081	$8,983	$31,377,584	$85,530,991
Labor Expense Indicators							
Labor Exp per CMI Adj Discharge*	$2,546	1	$2,547	$2,791	$3,323	$0	$0
Paid FTE per Adj Occupied Bed*	5.29	2	4.85	5.44	6.05	$0	$11,658,672
Paid FTE per CMI Adj Occupied Bed*	3.55	2	3.44	3.69	4.18	$0	$4,485,186
Labor and Benefit Exp as % of Net Patient Revenue*	34.0%	1	40.4%	47.7%	50.2%	$0	$0
Overtime Hours as % of Total Paid Hours	1.2%	1	2.3%	2.8%	3.7%	$0	$0
Agency/Contract Hours as % of Total Paid Hours	0.2%	1	0.5%	1.0%	1.7%	$0	$0
* Key Indicators utilized in Opportunity Analysis by Expense Category; use these indicators in combination to determine the 'average" opportunity.							
Supply Expense Indicators							
Supply Exp per CMI Adj Acute Discharge*	$1,881	4	$1,425	$1,587	$1,730	$15,332,898	$23,743,730
Supply Exp per CMI Adj Acute Patient Day*	$365	4	$279	$305	$352	$16,147,370	$22,891,220
Supply Exp as % of Net Patient Revenue*	19.1%	2	17.9%	19.4%	21.4%	$0	$6,174,236
Supply Exp as % of Total Operating Expense*	20.8%	3	18.2%	19.6%	21.9%	$5,735,502	$12,467,613
* Key Indicators utilized in Opportunity Analysis by Expense Category; use these indicators in combination to determine the 'average" opportunity.							
Other Expense Indicators							
Capital Eqmt Expense as a % of Total Operating Expense	1.1%	2	0.9%	2.1%	4.5%	$0	$734,543
Bad Debt as a % of Total Operating Expense	16.3%	4	2.7%	5.5%	9.0%	$50,532,245	$63,992,885
Amort/Deprec/Interest as a % of Total Operating Expense	7.3%	3	5.4%	7.0%	7.8%	$1,484,268	$8,965,446

Opportunity Analysis by Expense Category

Key Indicators of Labor Expense - Annualized



Key Indicators of Supply Expense - Annualized



Data Elements

All metrics in the "Facility Comparative Performance Report: Cost of Care" are generated using OperationsAdvisor or SupplyFocus data elements with the exception of the QUEST Primary Measure. Calculations are based on methodologies within these benchmark tools and can be provided upon request.

Please note: Data on this report is reported directly from the individual hospital and have not been verified nor subjected to audit.

Note: Some self-reported data was flagged for review in this report; review data elements for accuracy before taking improvement action.

Discharges - Total	5909
Discharges - Acute	5665
Patient Days - Acute	29224
Gross Patient Revenue	$373,233,996
Gross Patient Revenue OP	$131,248,303
Outpatient Adjustment Factor	0.648
Adjusted Occupied Bed (OA)	553
CMI Adjusted Occupied Bed (OA)	824
Net Patient Revenue	$127,982,254
CMI	1.490
CMI Adjusted Total Discharge	13580
CMI Adjusted Acute Discharge	13019
CMI Adjusted Acute Patient Day	67161

Facility Paid Hours	1502695
Overtime Hours	17822
Agency Hours	2530
Total Expense	$117,577,343
Labor Expense	$34,572,314
Average Hourly Rate	$23.01
Benefit Expense	$8,985,890
Supply Expense	$24,492,820
Bad Debt Expense	$19,114,624
Capital Eqmt Purchases	$1,282,075
Depreciation	$6,552,132
Amortization	$72,675
Interest	$1,937,862

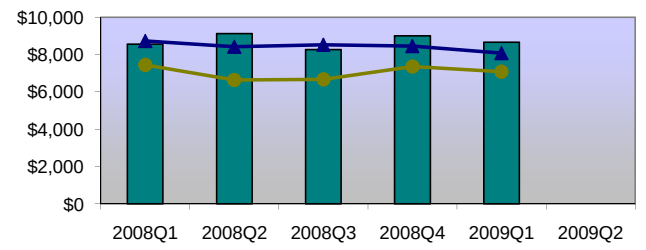
Facility Comparative Performance Report: Cost of Care

OperationsAdvisor™

Premier Memorial Medical Center – Anytown, US

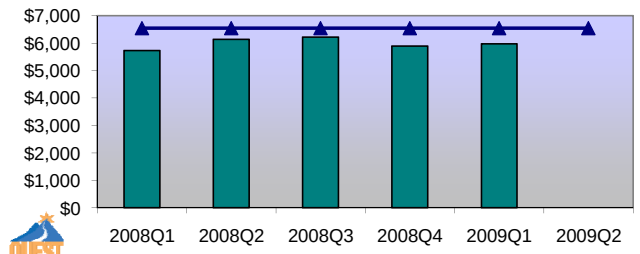
2009Q1

Total Hospital Expense per CMI Adjusted Discharge



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	$8561	$9115	$8264	$9004	$8658	No Data
25th Percentile	$7442	$6640	$6676	$7354	$7084	
50th Percentile	$8730	$8424	$8525	$8462	$8081	

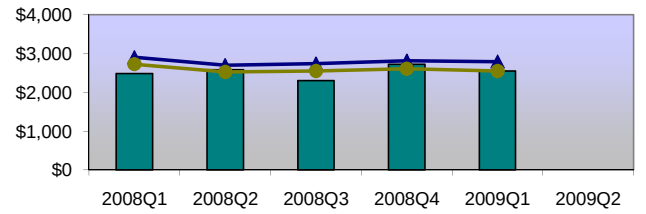
Total Inpatient Expense per CMI-Discharge (QUEST)



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	$5730	$6140	$6220	$5890	$5970	No Data
50th Percentile - TPT	$6540	$6540	$6540	$6540	$6540	$6540

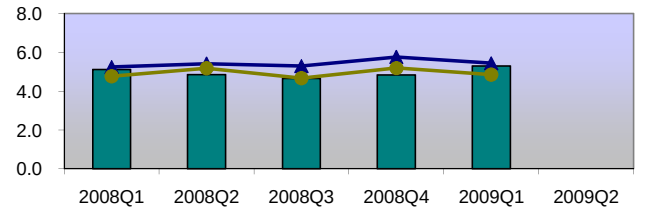
Labor Indicator Trends

Labor Expense per CMI Adjusted Discharge



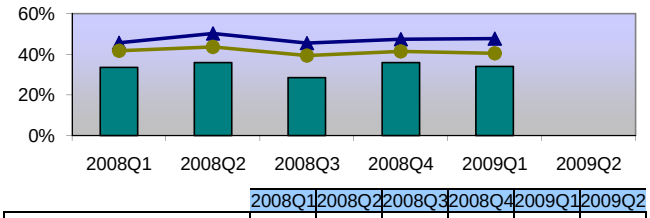
	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	$2481	$2584	$2298	$2726	$2546	No Data
25th Percentile	$2726	$2523	$2547	$2610	$2547	
50th Percentile	$2902	$2693	$2739	$2813	$2791	

FTE per Adjusted Occupied Bed



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	5.11	4.85	4.65	4.84	5.29	No Data
25th Percentile	4.76	5.19	4.66	5.19	4.85	
50th Percentile	5.24	5.42	5.29	5.76	5.44	

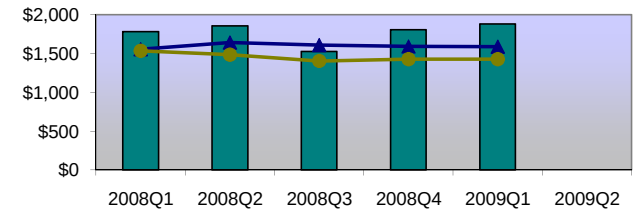
Labor Expense as Percent of Net Patient Revenue



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	33.5%	35.9%	28.4%	35.8%	34.0%	No Data
25th Percentile	41.7%	43.5%	39.3%	41.3%	40.4%	
50th Percentile	45.7%	50.2%	45.5%	47.4%	47.7%	

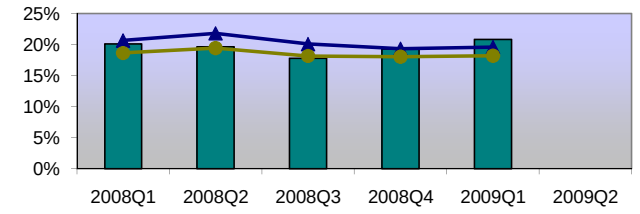
Supply Indicator Trends

Supply Expense per CMI Adjusted Acute Discharge



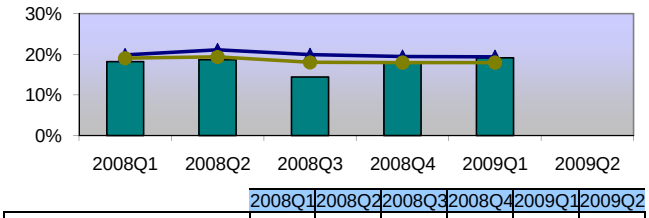
	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	$1781	$1857	$1527	$1807	$1881	No Data
25th Percentile	$1533	$1483	$1404	$1425	$1425	
50th Percentile	$1556	$1642	$1607	$1591	$1587	

Supply Expense as % of Total Operating Expense



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	20.1%	19.7%	17.8%	19.3%	20.8%	No Data
25th Percentile	18.6%	19.4%	18.2%	18.0%	18.2%	
50th Percentile	20.6%	21.8%	20.1%	19.3%	19.6%	

Supply Expense as Percent of Net Patient Revenue



	2008Q1	2008Q2	2008Q3	2008Q4	2009Q1	2009Q2
Premier Memorial Medical Center	18.1%	18.7%	14.4%	18.1%	19.1%	No Data
25th Percentile	19.0%	19.3%	18.0%	17.9%	17.9%	
50th Percentile	19.8%	21.0%	19.9%	19.4%	19.4%	

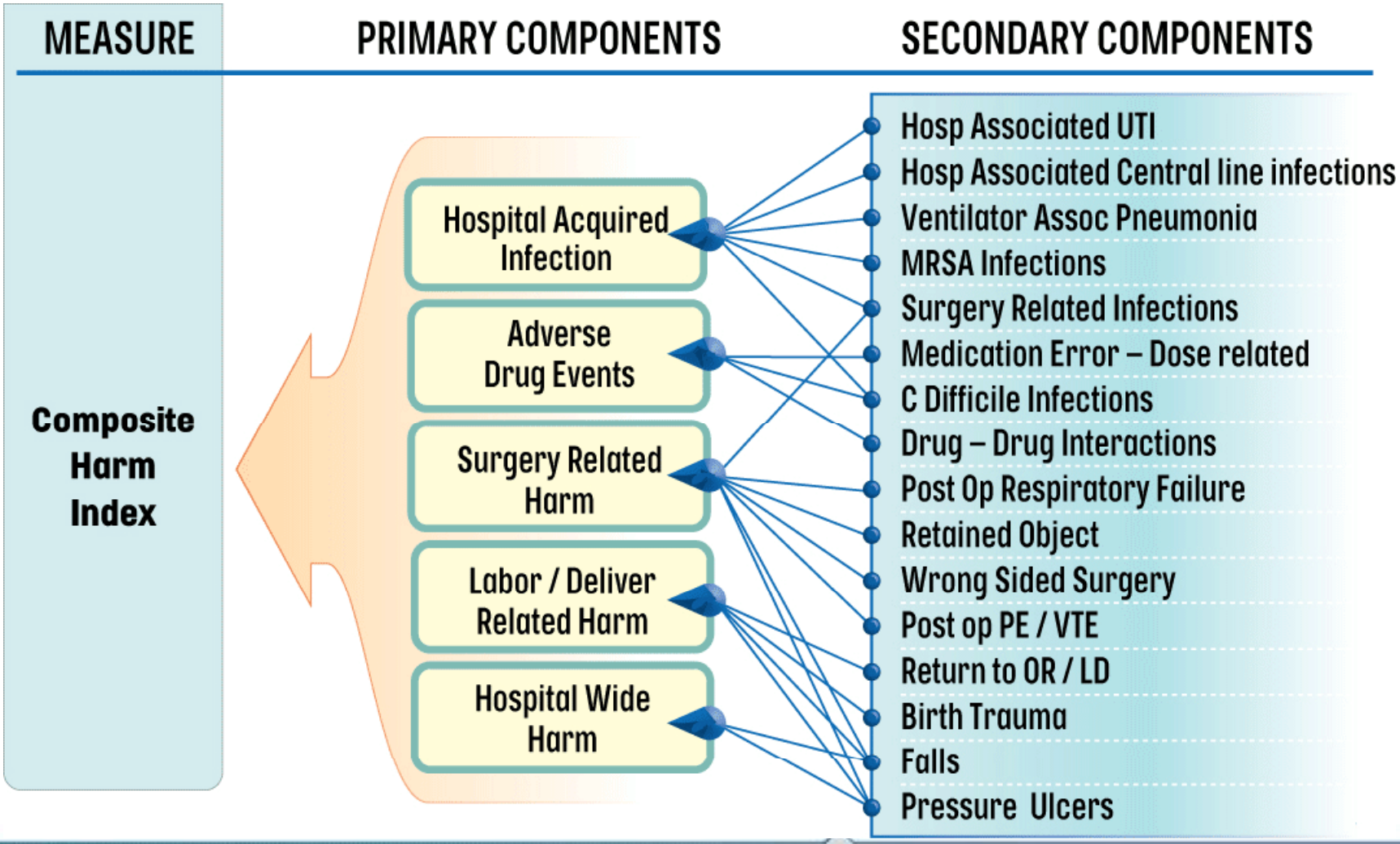
Facility Comparative Performance Report: Cost of Care

OperationsAdvisor™

Measure Definitions

Total Inpatient Expense per CMI-Discharge (QUEST)	See Cost of Care Framework document for full definition: http://www.premierinc.com/quest/members/qm-cost-of-care.jsp
Total Hospital Expense per CMI Adj Discharge	Total Operating Expense / (CMI * (Total Discharges / (1 - (Gross Outpatient Revenue / Gross Patient Revenue))) 2000 / (900 * 400 / (1 - (1020 / 1000)))
Labor Exp per CMI Adj Discharge	Labor Expense / (CMI * (Total Discharges / (1 - (Gross Outpatient Revenue / Gross Patient Revenue))) 2010 / (900 * 400 / (1 - (1020 / 1000)))
Paid FTE per Adj Occupied Bed	((Total Paid Hrs / (90 * 5.6986))/ ((Total Patient Days / 90) / (1 - (Gross Outpatient Revenue / Gross Patient Revenue))) ((950 / (90 * 5.6986)) / ((300 / DIQ) / (1 - (1020 / 1000)))
Paid FTE per CMI Adj Occupied Bed	((Total Paid Hrs / (90 * 5.6986))/ ((Total Patient Days / 90) / (CMI * (1 - (Gross Outpatient Revenue / Gross Patient Revenue)))) (950 / (90 * 5.6986)) / (900 * ((300 / 90) / (1 - (1020 / 1000))))
Labor and Benefit Exp as % of Net Patient Revenue	(Labor Exp + Benefit Exp) / Net Patient Rev (2010 + 2015) / 1030
Overtime Hours as % of Total Paid Hours	Total Overtime Hours / Total Paid Hours 960 / 950
Agency/Contract Hours as % of Total Paid Hours	Total Agency Hours / Total Paid Hours 970 / 950
Supply Exp per CMI Adj Acute Discharge	Supply Expense / (CMI * (Acute Discharges / (1 - (Gross Outpatient Revenue / Gross Patient Revenue))) 2020 / (900 * 410 / (1 - (1020 / 1000)))
Supply Exp per CMI Adj Acute Patient Day	Supply Expense / (CMI * (Acute PatDays / (1 - (Gross Outpatient Revenue / Gross Patient Revenue))) 2020 / (900 * 310 / (1 - (1020 / 1000)))
Supply Exp as % of Net Patient Revenue	Supply Exp / Net Patient Rev 2020 / 1030
Supply Exp as % of Total Operating Expense	Supply Exp / Total Exp 2020 / 2000
Capital Eqmt Expense as a % of Total Operating Exp	Capital Eqmt Exp / Total Exp 2610 / 2000
Bad Debt as a % of Total Operating Expense	Bad Debt Exp / Total Exp 2300 / 2000
Amort/Deprec/Interest as a % of Total Operating Exp	(Amortization Exp + Interest Exp + Depreciation Exp) / Total Exp (2150 +2200 + 2100) / 2000

Our Harm Measure and Potential Components



QUEST CHARTER MEMBER PERFORMANCE REPORT
HARM AVOIDANCE VERSION 1.0 DRILL DOWN REPORT: 2008Q3

To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial - Anytown, USA

Report Period: Jul08-Sep08 (7/1/2008-9/30/2008) **Report Generated: 6/2/2009**

Harm Avoidance

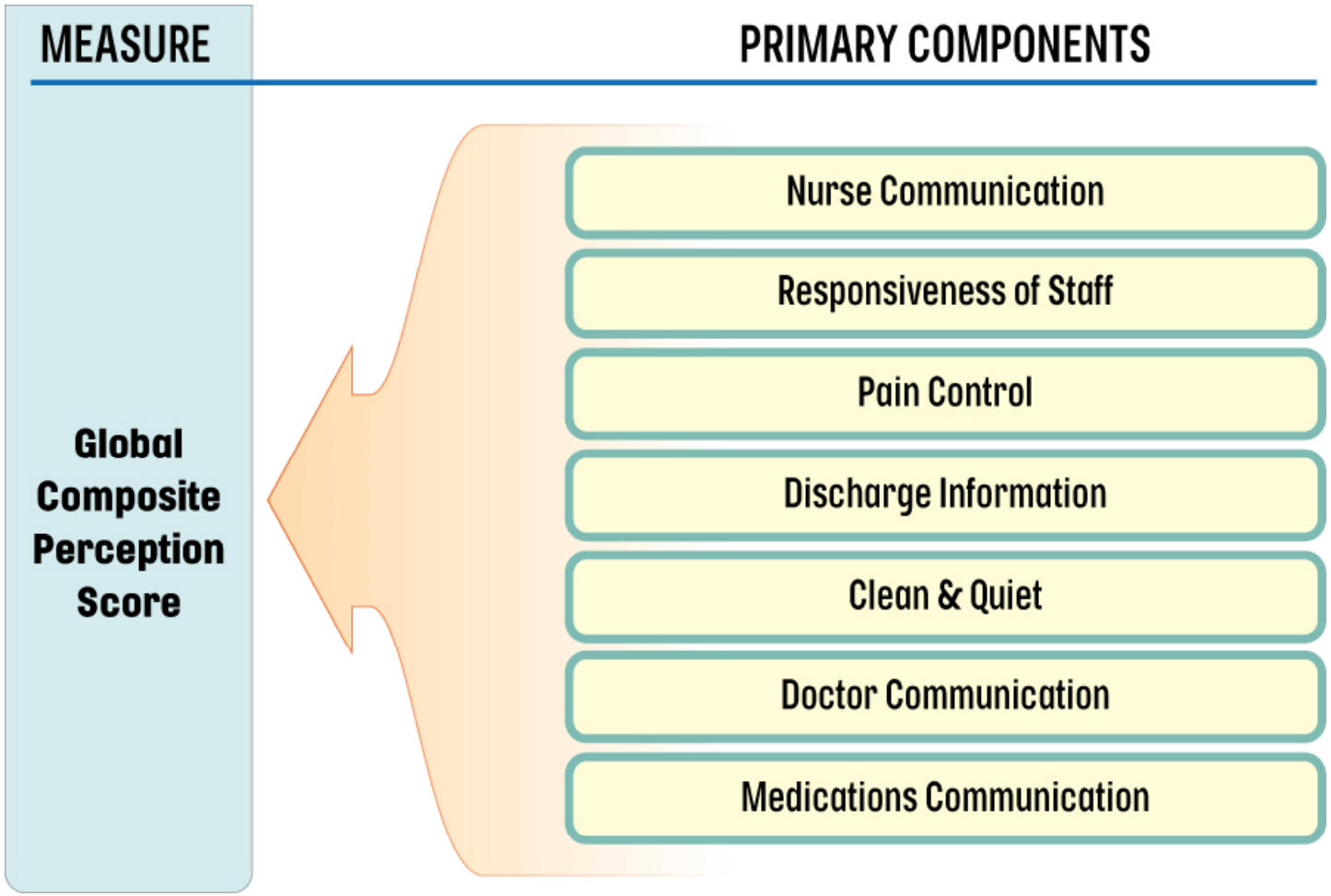
	Apr08-Sep08								Jul08-Sep08		
	Obsrvd Harm Rate	Percentile YTD					Obsrvd Count	Meas Denom	Obsrvd Harm Rate	Obsrvd Count	Meas Denom
		5th	10th	25th	50th	75th					
Adverse Drug Reactions: Composite											
QH-01: HA Benzodiazapine Assoc Event (per 100)	**0.90**	0.00	0.05	0.43	0.99	1.94	12	1,337	**0.16**	1	613
QH-02: HA Narcotic Assoc Event (per 100)	**2.13**	0.00	0.20	0.62	0.99	1.52	100	4,690	**2.34**	53	2,267
QH-03: HA Poisoning (per 100)	**0.01**	0.00	0.00	0.00	0.02	0.05	1	6,687	**0.00**	0	3,188
OB-GYN Related Measures: Composite											
QH-9 Uterine Rupture (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	1,506	**0.00**	0	776
QH-10 Birth Trauma birth wgt > 2500 gm or 37 wks (per 100)	**0.39**	0.00	0.00	0.07	0.22	0.38	6	1,546	**0.50**	4	808
QH-11 Birth Trauma birth wgt < 2500 gm or 37 wks (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.06	0	1,546	**0.00**	0	808
QH-12 Return to OR / LD (per 100)	**0.20**	0.00	0.00	0.16	0.31	0.52	3	1,506	**0.39**	3	776
QH-13 Maternal Blood Transfusion (per 100)	**0.53**	0.00	0.00	0.00	0.17	0.39	8	1,506	**0.26**	2	776
QH-14 3rd or 4th Degree Perineal Laceration (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	1,506	**0.00**	0	776
QH-15 Normal Newborn Tnfr to a Higher Lvl of Care (per 100)	**11.21**	0.00	0.00	0.00	2.50	10.47	172	1,534	**12.70**	102	803
Surgery Related Measures: Composite											
QH-16 Complication Associated with Anesthesia (per 100)	**0.13**	0.00	0.00	0.00	0.07	0.16	4	2,984	**0.00**	0	1,432
QH-17 Postop Physiologic & Metabolic Derangement (per 100)	**0.16**	0.00	0.00	0.00	0.04	0.14	3	1,910	**0.00**	0	879
QH-18 Postoperative Wound Dehiscence (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	328	**0.00**	0	162
QH-19 Postoperative Respiratory Failure (per 100)	**0.76**	0.00	0.00	0.28	0.73	1.06	12	1,585	**0.97**	7	724
QH-20 Wrong Site Surgery (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	6,687	**0.00**	0	3,188
QH-24 DVT / PE after certain Orthopedic Surgeries (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.36	0	112	**0.00**	0	51
Hospital Wide Harm: Composite											
QH-25 Air Embolism (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	6,431	**0.00**	0	3,058
QH-26 ABO Blood Incompatibility (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	6,687	**0.00**	0	3,188
QH-27 Hospital Acquired Injury (per 100)	**0.01**	0.00	0.00	0.00	0.05	0.08	1	6,687	**0.03**	1	3,188
QH-28 Hospital Acquired Pressure Ulcers - Stage 3/4 (per 100)	**0.16**	0.00	0.00	0.05	0.14	0.25	11	6,687	**0.19**	6	3,188
QH-29 Retention of a Foreign Object (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	6,687	**0.00**	0	3,188
QH-30 Poor Glycemic Control (per 100)	**0.00**	0.00	0.00	0.00	0.00	0.01	0	6687	**0.00**	0	3,188
Hospital Acquired Infections: Composite											
QH-04: HAI Clostridium Difficile											
Commonly Used Standard: Incidents per 1000 Days (SSI)											
QUEST Phase I Methodology: Incidents per 100 Patients (ICD9)	**0.24**	0.00	0.00	0.09	0.26	0.47	8	3,267	**0.38**	6	1,578
QH-05: HAI Staphylococcus Aureus Septicemia											
Commonly Used Standard: Incidents per 1000 Days (SSI)											
QUEST Phase I Methodology: Incidents per 100 Patients (ICD9)	**0.01**	0.00	0.00	0.00	0.02	0.05	1	6,687	**0.00**	0	3,188
QH -06: HAI Central Line Associated Blood Stream Infections											
NHSN Methodology: Incidents per 1000 Central Line Days (SSI)											
QUEST Phase I Methodology: Incidents per 100 Patients (ICD9)	**0.50**	0.00	0.00	0.00	0.69	1.91	2	398	**0.57**	1	174
QH-07: HAI Catheter Assoc Urinary Tract Infections											
NHSN Methodology: Incidents per 1000 Days (SSI)											
QUEST Phase I Methodology: Incidents per 100 Patients (ICD9)	**4.04**	0.00	0.00	0.00	2.69	4.63	29	717	**4.25**	15	353
QH-08: Ventilator Associated Pneumonia											
NHSN Methodology: Incidents per 1000 Vent Days (SSI)											
QUEST Phase I Methodology: Incidents per 100 Patients (ICD9)	**9.98**	0.00	0.00	3.60	9.17	12.96	45	451	**6.61**	15	227
QH-21: Mediastinitis after Coronary Artery Bypass Graft (SSI)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	89	**0.00**	0	49
QH-22: Infections after certain Orthopedic Procedures (SSI)	**0.00**	0.00	0.00	0.00	0.00	0.00	0	186	**0.00**	0	74
QH-23: Infections after Bariatric Surgical Procedures (SSI)											

For more information on the Harm measures, please find the Harm Definitions on the Performance Improvement Portal: http://premier.involvetechnology.com/si?iid=11838

Top Performance Thresholds are based on historical data (mmddyyyy to mmddyyyy). These Thresholds are FINAL and will represent the goal of QUEST for three years. For questions about this report, or any QUEST related topic, contact your Premier QUEST Sponsor:

BJ Phansiri: BJ_Phansiri@premierinc.com

Our Patient Experience Measure and Potential Components



Patient Experience:
Sample Report - Hospital Level

Sample Premier Quest Participant Patient Satisfaction Summary Report
Hospital Service Level

Medicare ID	Hospital	Service	HCAHPS Dimension	Completed Surveys	Completed Dimension	Unadjusted Performance Score	Patient Mix Adjusted Performance Score	Adjusted percentage for top rating
000000	Quest Memori	Maternity	Communication with Nurses	23	23	2.80	2.81	83.60
000000	Quest Memori	Maternity	Communication with Doctors	23	23	2.75	2.77	81.84
000000	Quest Memori	Maternity	Responsiveness of Hospital Staff	23	22	2.71	2.71	73.01
000000	Quest Memori	Maternity	Pain Management	23	20	2.75	2.76	81.59
000000	Quest Memori	Maternity	Communication about Medicines	23	15	2.47	2.50	68.52
000000	Quest Memori	Maternity	Discharge Information	23	21	0.60	0.60	60.03
000000	Quest Memori	Maternity	Cleanliness of Hospital Environment	23	23	2.43	2.45	58.03
000000	Quest Memori	Maternity	Quietness of Hospital Environment	23	23	2.43	2.46	62.80
000000	Quest Memori	Maternity	Overall Rating of Hospital	23	23	2.52	2.54	57.72
000000	Quest Memori	Maternity	Willingness to Recommend Hospital	23	22	2.64	2.64	63.51
000000	Quest Memori	Maternity	Premier Composite	23	21	2.66	2.67	73.47
000000	Quest Memori	Medical	Communication with Nurses	167	167	2.53	2.51	59.93
000000	Quest Memori	Medical	Communication with Doctors	167	167	2.60	2.58	67.39
000000	Quest Memori	Medical	Responsiveness of Hospital Staff	167	139	2.29	2.26	43.41
000000	Quest Memori	Medical	Pain Management	167	80	2.45	2.41	52.89
000000	Quest Memori	Medical	Communication about Medicines	167	99	2.23	2.17	50.23
000000	Quest Memori	Medical	Discharge Information	167	131	0.77	0.76	75.95
000000	Quest Memori	Medical	Cleanliness of Hospital Environment	167	163	2.52	2.49	61.81
000000	Quest Memori	Medical	Quietness of Hospital Environment	167	162	2.17	2.13	38.08
000000	Quest Memori	Medical	Overall Rating of Hospital	167	166	2.46	2.42	55.66
000000	Quest Memori	Medical	Willingness to Recommend Hospital	167	166	2.57	2.54	60.92
000000	Quest Memori	Medical	Premier Composite	167	130	2.40	2.37	52.95

QUEST CHARTER MEMBER PERFORMANCE REPORT

Final Results: 2008Q3

Released 03-31-2009

To achieve unprecedented results in quality, safety, and efficiency

Premier Memorial - Anytown, USA

Evidence-Based Care

Measure Results	Measure Status	Hospital Evidence-Based Care Rate	Variation from Top Performance Threshold	Top Performance Threshold	Measure Num	Measure Denom	Total Eligible Discharges	Top Quartile for Period	Top Decile for Period
All-or-None Composite Current Quarter Jul08-Sep08	●	**68%**	-16%	84%	26	38	48	92%	95%
All-or-None Composite Year to Date Jan08-Sep08	●	**70%**	-14%	84%	59	84	113	91%	94%
All-or-None Composite Rolling 4 Quarters Jan08-Sep08	●	**70%**	-14%	84%	59	84	113	91%	94%

Cost of Care: NonTeaching < 175 Beds

Measure Results	Measure Status	Hospital Total Inpatient Cost per Case Mix Adj Discharge	Variation from Top Performance Threshold	Top Performance Threshold		Total Eligible Discharges	Median for Period	Top Quartile for Period
Cost per Adj Discharge Current Quarter Jul08-Sep08	●	**$5,600**	$430	$5,170		143	$5,040	$4,305
Cost per Adj Discharge Year to Date Jan08-Sep08	☆	**$5,070**	-$100	$5,170		485	$4,950	$4,270
Cost per Adj Discharge Rolling 4 Quarters Jan08-Sep08	☆	**$5,070**	-$100	$5,170		485	$4,950	$4,270

Note: Cost of Care data is considered preliminary until calculated Case Mix Index is available.
If Cost of Care data was submitted but is not shown, preliminary results are provided on the Cost of Care Drill Down Report.

Mortality

Data Reported Through: Sep 2008

Measure Results	Measure Status	Hospital O/E Ratio	Variation from Top Performance Threshold	Top Performance Threshold	Observed Rate	Expected Rate	Total Eligible Discharges	Top Quartile for Period	Top Decile for Period
Severity-Adjusted Mortality Current Quarter Jul08-Sep08	●	**1.26**	0.44	0.82	2.8%	2.2%	36	0.62	0.45
Severity-Adjusted Mortality Year to Date Jan08-Sep08	●	**1.49**	0.67	0.82	2.7%	1.8%	407	0.70	0.59
Severity-Adjusted Mortality Rolling 4 Quarters Jan08-Sep08	●	**1.49**	0.67	0.82	2.7%	1.8%	407	0.70	0.59

Note: Mortality data is considered preliminary until all months in the quarter are submitted.

Performance Key

☆ Performance is better than or equal to the top performance threshold

● Performance is not meeting the top performance threshold

Source for Teaching Status and Total Beds: QUEST Demographic Survey
Measure definitions on Report Definitions Page

* Top Performance Thresholds for EBC, Cost, and Mortality are based on historical data (7-1-2006 to 6-30-2007) for those hospitals fully in the QUEST Program as of 12/31/2007.

These Thresholds are FINAL and will represent the goal of QUEST for three years; Cost of Care will be reviewed once MSDRG CMI analysis is complete. There are no top performance thresholds for subsets of the measures - AMI, PNE, etc. Though Efficiency performance thresholds are shown for all categories, your institution's cost is displayed only in the applicable category. Total discharges refer to total discharges on which the metric is based and may differ slightly among metrics. Mortality O/E Ratio is calculated using CareScience risk assessment methodology. For questions about this report contact your Premier QUEST Sponsor listed below. "MissingData" indicates only partial data is available for the quarter on a Final Report; "NoData" indicates no data has been provided and/or available.

Premier Quest Sponsor: Roger Jones: roger_jones@premierinc.com

QUEST CHARTER MEMBER PERFORMANCE REPORT
REPORT DEFINITIONS

Evidence-Based Care:

Also known as the "perfect process" score or all-or-none score. The Evidence-Based Care Score is a measure of the rate that patients received all the care they were eligible to receive. It is the total number of patients that received all the care they w

Focus Area	Measure ID	Process Measure Name
Acute Myocardial Infarction (AMI)	AMI-1	Aspirin at arrival
	AMI-2	Aspirin prescribed at discharge
	AMI-3	ACEI or ARB for LVSD
	AMI-4	Adult smoking cessation advice/counseling
	AMI-5	Beta-blocker prescribed at discharge
	AMI-6	Beta-blocker at arrival
	AMI-7a	Fibrinolytic agent within 30 minutes of hospital arrival
	AMI-8a	Primary PCI within 90 minutes of hospital arrival
Heart Failure (HF)	HF-1	Discharge Instructions
	HF-3	ACEI or ARB for LVSD
	HF-4	Adult smoking cessation advice/counseling
Pneumonia (PN)	PN-2	Pneumococcal vaccination
	PN-3b	Blood Culture Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
	PN-4	Adult smoking cessation advice/counseling
	PN-6	Initial antibiotic selection for CAP immunocompetent patients
	PN-7	Influenza Vaccination
Surgical Care Improvement Project (SCIP)	SCIP-INF-1a	Prophylactic antibiotic received within 1 hour prior to surgical incision
	SCIP-INF-2a	Prophylactic antibiotic selection for surgical patients
	SCIP-INF-3a	Prophylactic antibiotics discontinued within 24 hours after surgery end time /48 hours for CABG or Other Cardiac Surgery
	SCIP-VTE-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery up to 24 hours after surgery end time

Each patient is evaluated and counted separately.
If a patient is eligible for measures in multiple populations, they are only evaluated once across all eligible populations and measures

For each measure, the measure category assignment value submitted allows for determining if, at the patient level, the measure passed, failed or was not qualified for. A value of A, B, C or X indicates a patient did not qualify for a measure and thus is

Mortality:

Severity-Adjusted Mortality Ratio using the CareScience methodology. Mortality is risk-adjusted independently and given its own expected outcome (risk) that is matched to the observed outcome (raw rate). The index (O/E Ratio) is then calculated from these

Calibration Database - The calibration database is used to determine the beta coefficients or weighting factors for all independent variables (associated patient risk factors) over the 142 disease strata for each outcome risk model (mortality, LOS, compli

The following patient characteristics and socioeconomic factors comprise the set of patient risk factors used in the CareScience Methodology to adjust results to ensure fair comparisons.

-Age or
Birth weight (for neonatal model only)

-Sex (female, male, unknown)

-Race (white, black, asian-pacific islander, other, unknown)

-Income (median household income within a zip code reported by US Census Bureau)

-Distance traveled (the centroid-to-centroid distance between the zip code of the household and the zip code of the hospital or provider, represented as a relative term)

-Principal diagnosis (terminal or three digit ICD-9-CM code, where statistically significant)

-CareScience comorbidity scores (count of comorbidities within each of five severity categories)

-Cancer status (benign, malignant, carcinoma in situ, history of cancer, derived from secondary diagnoses)

-Chronic disease and disease history (terminal digit ICD9-CM diagnosis codes, such as diabetes, renal failure, hypertension, chronic gastrointestinal, chronic cardiopulmonary, obesity, and history of substance abuse)

-Valid procedure* (terminal ICD9-CM procedure codes, where clinically relevant and statistically significant)

*In the CareScience methodology, procedures are considered valid based on clinical knowledge of the patient's disease stratum and the time from admission to when the procedure occurs. Even if the procedure is known to be clinically relevant for assessing

-Admission source (Physician Referral, Clinic Referral, HMO Referral, Transfer from a Hospital, Skilled Nursing Facility or Another Health Care Facility, Emergency Room, Court/Law Enforcement, Newborn - Normal Delivery, Premature Delivery, Sick Baby, or E

-Admission type (Emergency, Urgent, Elective, Newborn, Delivery, Unknown/Other)

-Payor class (Self-pay, Medicaid, Medicare, BC/BS, Commercial, HMO, Workman's Compensation, CHAMPUS/FEHP/Other Federal Government, Unknown/Other)

Patients are excluded from the denominator if they were transferred to another acute-care facility or if they are missing a value that is critical to the CareScience methodology. Principal diagnosis, outcome, age, and birth weight (for immature newborns)

Statistical Significance - Taking into account the statistical error of the risk model, significance flags indicate whether the O/E ratio differs significantly from 1, either above 1 (worse than expected) or below 1 (better than expected). Significance a

Hospice patients are those for whom the institution has specifically coded "hospice-care." Using a specific code for hospice indicates that these patients are receiving a level of care that is distinct from acute inpatient care, and as such these patients will be excluded from the mortality measure. These patients may be housed in a distinct "hospice unit," or in some cases may be housed in the same physical acute care unit, but would have been discharged from acute care, and readmitted to "hospice-care." This approach is exactly analogous to the method by which SNF patients are handled. To further clarify, Rehab, SNF, Psych, Long Term Care, Chemical Dependency and hospice-care patients who receive (and are billed for) care that is distinct from acute inpatient care, will not be included in the QUEST mortality population.

Cost of Care:

Total Inpatient Cost per Case Mix Adjusted Discharge. The operational definition is total operating expenses adjusted for both wages and outpatient and non-patient revenue divided by case mix adjusted discharges. The information is collected from the Gene

$$\frac{\text{Wage Adjustment Factor X Total Operating Expense X Inpatient Adjustment Factor}}{\text{Overall Case Mix Index X Total Inpatient Discharges}}$$

Inpatient Adjustment Factor: Total Inpatient Gross Revenue / (Total Gross Revenue + Other Operating Revenue – Investment Income)
(Adjustment to account for only inpatient expenses and exclude outpatient expenses)

Wage Adjustment Factor: Labor Cost Ratio / Wage Index + 1 - Labor Cost Ratio
(Controls for systematic regional variation in labor market conditions and wages)

Wage index and labor cost ratio are taken from available MedPAR data and applied to total inpatient operating expense to adjust for geographic labor cost variation.

Adjusted for inpatient hospital services inflation over time

Goals are set for each of four segments, based on teaching status and bed size as obtained through the QUEST demographic survey distributed in February 2008 and completed by each charter member. If the survey was not completed, MedPar data was utilized.

Teaching >= 375 beds

Teaching <375 beds

Non-teaching >= 175 beds

Non-teaching <175 beds

A teaching facility is one that is affiliated with a medical school, offers formal postgraduate residency programs or supports residency rotations.
Non-Teaching Hospitals have no affiliation.

The following five data points are submitted from each participating QUEST facility:

1. Total Operating Expense excluding Interest, Depreciation, Bad Debt and Amortization
   Represents all expenses incurred due to operations of the facility. The expenses include but are not limited to labor expense, direct fringe benefits, supply expense, and other expense. Interest, depreciation, bad debt and amortization should be excluded
2. Total Gross Revenue
   Represents full hospital revenue for all hospital patient services before considering any deductions for bad debts, charity care or contractual allowances.
3. Total Inpatient Gross Revenue
   Represents full hospital revenue from inpatients for hospital services before considering any deductions for bad debt, charity care or contractual allowances.
4. Other Operating Revenue less Investment Income
   Represents all revenue generated from hospital operations other than revenue directly associated with patient care. Investment Income should be excluded.
5. Total Discharges
   Represents adult and pediatric inpatients who were discharged from the hospital and included in gross inpatient revenue. Normal newborn (Level I) discharges should be excluded.

The data for Case Mix beginning with 1Q2008 is taken from one of three sources, in prioritized order: 1) self-submitted CMI, 2) same quarter previous year, or 3) baseline. For finalized quarterly reports, the Case Mix will be pulled based on finalized calculated DRG or MSDRG CMI.

QUEST Collaborative Execution Examples

Track 1	Room
Track 2	Room
Track 3	Room
Track 4	Room

QUEST National Meeting Agenda

DRAFT AGENDA

MONDAY, June **7, 2010**

2:00 pm – 6:00 pm	Registration			
	QUEST Workshops			
2:00 pm - 4:00 pm	**Sepsis**	**QUEST 2010 Session**	**Patient Experience**	**Cost of Care: Labor Management**
4:00 pm – 4:30 pm	Welcome			
4:30 pm – 6:00 pm	"The Case for Improving Palliative Care" – Judith Eve Nelson, M.D., J.D.			
6:00 pm – 8:00 pm	Reception			

TUESDAY, June 8, 2010

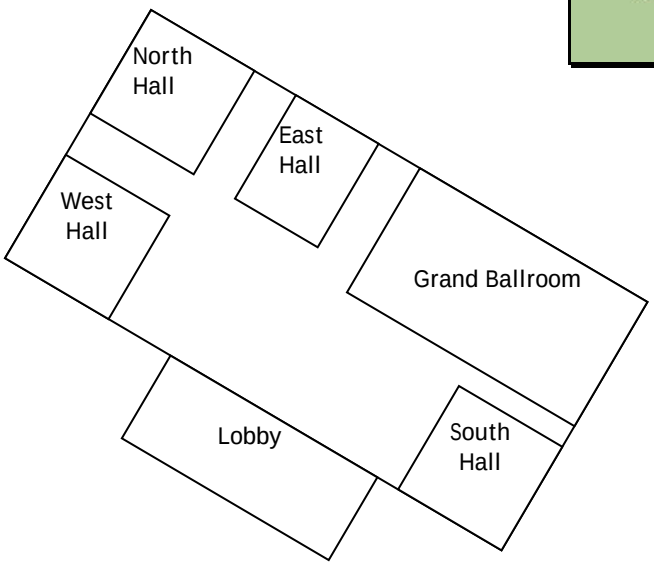
7:00 am – 8:00 am	Breakfast Buffet			
8:00 am – 8:30 am	Housekeeping Items			
8:30 am – 9:15 am	"Reducing Hospital Readmissions – The Time is Now", Harlan Krumholz, MD, SMM, Professor of Medicine, Yale University			
9:15 am – 9:30 am	Break/Transition to next Concurrent			
9:30 am - 10:30 am	**IHI Improvement Map – Christina Gunther-Murphy**	**End of Life/Palliative Care - Andrea Mazzoccoli - BonSecours**	**Cost of Care - Resource Utilization - Presbyterian Albuquerque**	**CaUTI - Linda Green Rochester General**
10:30 am – 10:45 am	Break/Transition to next Concurrent			
10:45 am - 11:45 am	**"Bruised but Not Bleeding" - Improving VTE - Monical Barrington, RPh, MPH, FASCP**	**End of Life/Palliative Care - Andrea Mazzoccoli - BonSecours**	**Cost of Care - Resource Utilization - Presbyterian Albuquerque**	**CaUTI - Linda Green Rochester General**
11:45 am – 1:30 pm	Networking Lunch Break/Trade Show Exhibits			
1:30 pm - 2:30 pm	**Premier Research Services - Gene Kroch**	**Premier Research Services QUEST - Comparative Effectiveness & Innovation Program - Bill Zeruld**	**Perinatal**	**OPPE - Premier Practitioner Measurement - Bryan Bowles, Richard Bankowitz, MD, and Barb Doyle**
2:30 pm – 2:45 pm	Break/Transition to next Concurrent			

2:45 pm - 3:45 pm	**Baldrige Panel - Heartland, Atlanticare, and N. Mississippi - Conducted by Jan Englert**	**Patient Experience - HCAHPS Survey - Charleston Area Medical Center and St. Joseph Orange**	**Sepsis - Leslie Schultz, RN, PhD,**	**Harm C-Diff, Christine Hendrickson, Fairview**
3:45 pm - 4:45 pm	How to Appropriate code? Pallative Care, DNR, Coding			
4:45 pm - 5:00 pm	Closing/Questions/Reminders/Incentive for Goal			

WEDNESDAY, January 21, 2004

8:00 am – 4:00 pm	Registration				
8:00 am – 9:00 am	Continental Breakfast				
9:00 am – 10:30 am	Exhibits Open	**Keynote Address: Mandar Naik,** Industry Trends for the Decade Ahead **(Grand Ballroom)**			
10:45 am - 12:00 pm		**Outsourcing Your Work (North Hall)**	**Advertising on the Internet (South Hall)**	**Automation (East Hall)**	**Evaluating and Comparing Tools (West Hall)**
12:00 pm – 1:30 pm		Lunch Break			
1:30 pm – 3:00 pm		**Running a Tight Ship and Still Having Fun (North Hall)**	**Market Testing Your Products (South Hall)**	**Exceeding Industry Standards (East Hall)**	**Efficiency Is Key (West Hall)**
3:15 pm – 5:00 pm	Closing Ceremonies				

Map of Conference Center Location and Floor Plan



QUEST
High Performing Hospital Collaborative
A PROGRAM OF THE PREMIER HEALTHCARE ALLIANCE™

PREMIER | Transforming Healthcare Together®

Cost of Care Collaborative: Labor Management

INFORMATIONAL CALL ON WEDNESDAY, FEBRUARY 3, 2010, AT 3 P.M. ET

QUEST® is all about improvement! Our next collaborative is focused on:

Cost of Care

One of the goals of QUEST is to improve the cost of care. Our next collaborative will focus on using labor management methodologies to achieve performance improvement across clinical and operational practices.

The objective of this collaborative is to focus on rapid execution of proven better practices related to labor management and cost of care. Our goal is to identify specific practices and costs that drive labor expense. We will review various improvement strategies over the course of the collaborative.

The collaborative will take place over six months. There will be prework, conference calls, monthly homework and one face-to-face meeting.

At the completion of the collaborative, participants will be able to:

- Understand how to appropriately use labor management and benchmarking as a performance improvement tool;
- Assess clinical utilization as a driver of labor cost;
- Test and implement key interventions to improve the cost of patient-centered care;
- Understand how to measure the relationship between the interventions and quality of care; and
- Identify areas for future improvement.

Enrollment is open to any QUEST member hospital; there is no fee to participate. Please take a moment to **REGISTER** for the recruiting webinar. *Note: The link to the webinar information will be sent once your registration is processed.*

>> MARK YOUR CALENDARS!

- **Wednesday, February 3**
  3–4 p.m. ET
  Informational call
- **Wednesday, March 3**
  3–4 p.m. ET
  Understanding Labor Management
- **Wednesday, April 7**
  3–4 p.m. ET
  Benchmarking Clinical Practices to Identify Potential Staffing Opportunities
- **Wednesday, May 5**
  3–4 p.m. ET
  Practices to Ensure Appropriate Staffing (part 1)
- **Face-to-face meeting at the QUEST National Meeting in June (one hour)**
  Practices to Ensure Appropriate Staffing (part 2)
- **Wednesday, July 7**
  3–4 p.m. ET
  Key Tools and Resources Available

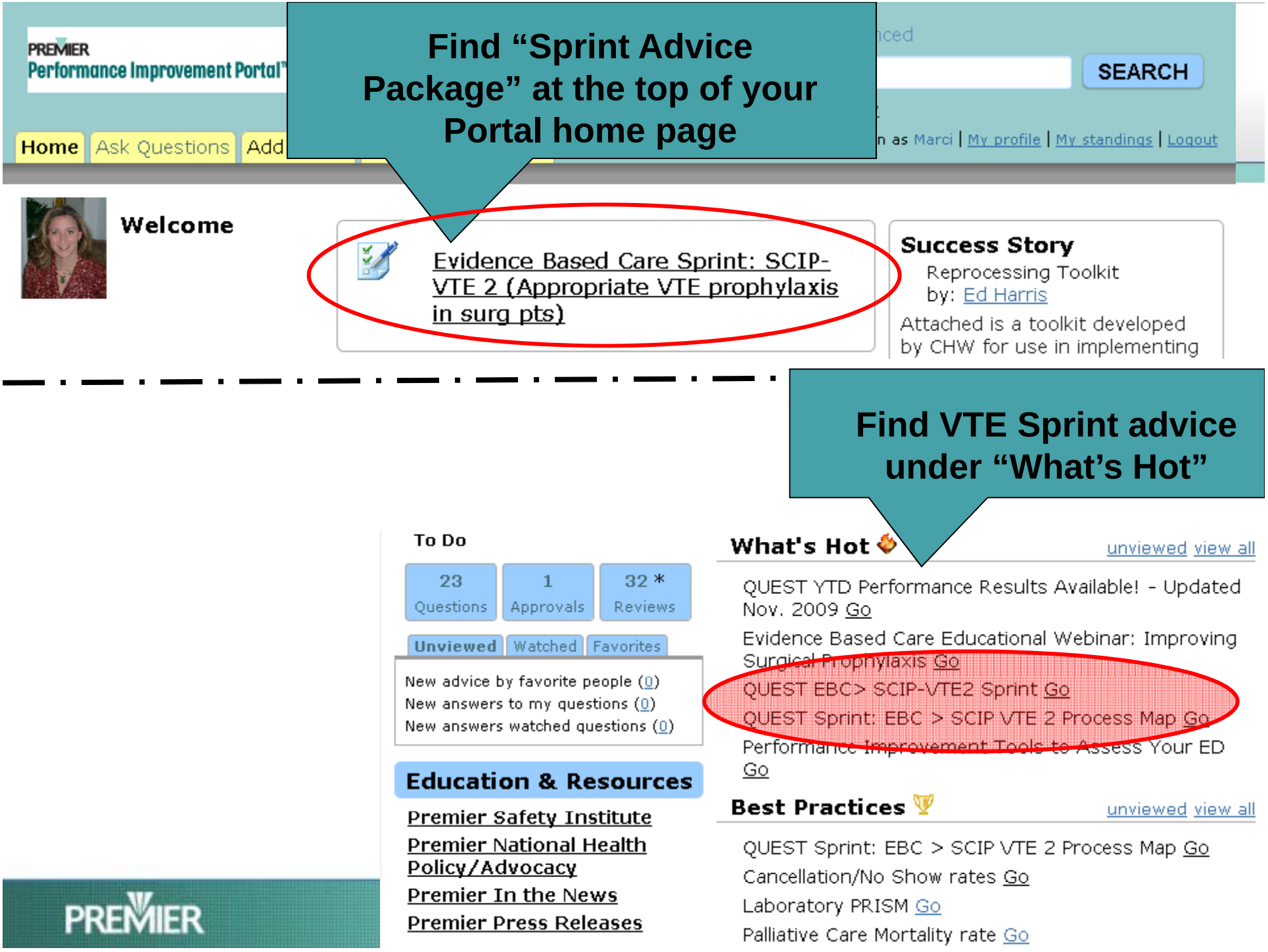
>> WHO SHOULD ATTEND?

- Managers
- Directors
- Nurses
- Physicians
- Quality leaders
- Quality staff
- Chief nursing officers
- Chief medical officers
- Chief financial officers
- Finance/decision support staff
- Ancillary staff
- Management engineers

FOR QUESTIONS, PLEASE CONTACT

Leigh Ann Myers
leighann_myers@premierinc.com

Performance Improvement Portal


PREMIER
Performance Improvement Portal
SEARCH
Home
Ask Questions
Add
n as Marci | My profile | My standings | Logout
Find "Sprint Advice Package" at the top of your Portal home page
Welcome
Evidence Based Care Sprint: SCIP-VTE 2 (Appropriate VTE prophylaxis in surg pts)
Success Story
Reprocessing Toolkit
by: Ed Harris
Attached is a toolkit developed by CHW for use in implementing
Find VTE Sprint advice under "What's Hot"
To Do
23 Questions
1 Approvals
32 * Reviews
Unviewed
Watched
Favorites
New advice by favorite people (0)
New answers to my questions (0)
New answers watched questions (0)
Education & Resources
Premier Safety Institute
Premier National Health Policy/Advocacy
Premier In the News
Premier Press Releases
What's Hot
unviewed view all
QUEST YTD Performance Results Available! - Updated Nov. 2009 Go
Evidence Based Care Educational Webinar: Improving Surgical Prophylaxis Go
QUEST EBC> SCIP-VTE2 Sprint Go
QUEST Sprint: EBC > SCIP VTE 2 Process Map Go
Performance Improvement Tools to Assess Your ED Go
Best Practices
unviewed view all
QUEST Sprint: EBC > SCIP VTE 2 Process Map Go
Cancellation/No Show rates Go
Laboratory PRISM Go
Palliative Care Mortality rate Go
PREMIER

Sprint Advice Package = 15 pieces of cherry-picked, relevant content from the PI Portal

Evidence Based Care Sprint: SCIP-VTE 2 (Appropriate VTE prophylaxis in surg pts)

QUEST Sprint

SCIP VTE 2: Surgery pts who rec'd appropriate VTE prophylaxis within 24 hrs prior to surgery up to 24 hours after surgery end time

15 matches found

Page 1 of 1 • << < 1 > >>

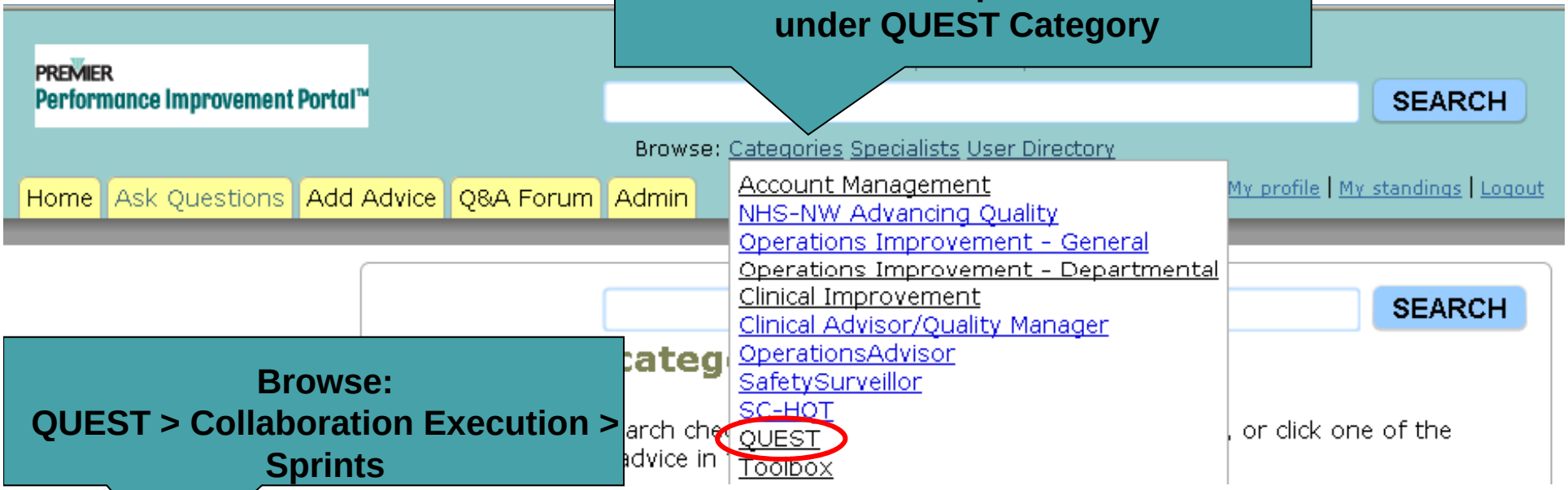
Sort by:

Antithrombotic & Thrombolytic Therapy, 8th Ed ACCP Guidelines
From CHEST on-line journal June, 2008. Vol 133, #6 supplement. "Antithrombotic and thrombolytic therapy, 8th Ed, ACCP guidelines" A must read! You can...
Clinical Improvement > VTE (venous thromboembolism)
by Leslie Schultz | Last Updated: 12/16/2008
61 views
0 comments

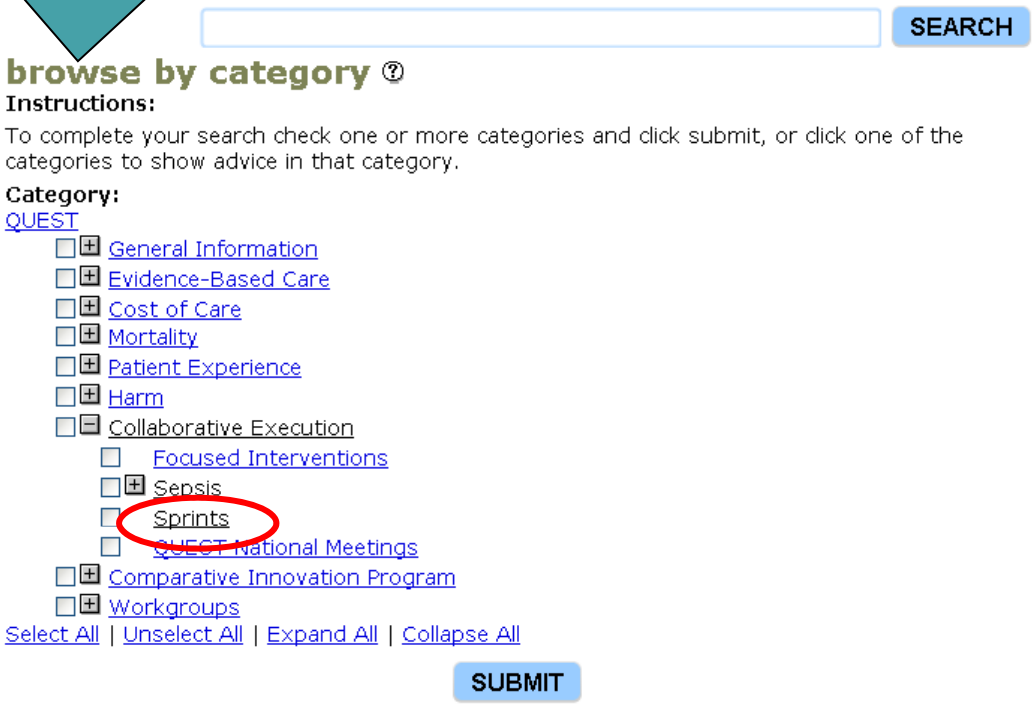
Report on DVT/PE from Surgeon General
The Office of the Surgeon General launched a major effort to reduce the number of deep vein thrombosis (DVT) and pulmonary embolism (PE) cases in the United...
Clinical Improvement > VTE (venous thromboembolism)
by Heather Vass | Last Updated: 10/05/2009
61 views
0 comments

AHRQ Resources: Preventing Hospital-Acquired VTE
Two AHRQ guides can help consumers and clinicians prevent and treat deep vein thrombosis. AHRQ's consumer booklet, Your Guide to Preventing and Treating Blood...
Clinical Improvement > VTE (venous thromboembolism)
by Heather Vass | Last Updated: 10/05/2009
64 views
0 comments

… OR Find "Sprint" advice under QUEST Category



Browse:
QUEST > Collaboration Execution > Sprints



PI Portal Sprint Advice

QUEST Sprint: EBC > SCIP VTE 2 Process Map

by: Leslie Schultz **last update:** 11/18/2009

Attachments

VTE2 Process Map
Adobe Acrobat Document - 64K <1 min @ 28.8K

VTE (venous thromboembolism), including DVT (deep vein thrombosis) and PE (pulmonary embolism) is the most common preventable cause of hospital death in the United States. Despite existence of evidence-based guidelines, implementation of the recommendations remains a challenge.

In this Sprint, we are focused on one element of the QUEST Evidence-Based Care (EBC) domain: "SCIP VTE2" – timing of VTE prophylaxis in surgical patients. As with other QUEST Sprints, we have compiled best practices, tenets of reliability and tools/resources into a single, "enabled" process map. If you have reviewed your EBC data, and if SCIP VTE2 is a leveraged area of improvement for you, read this posting thoroughly and carefully review the attached process map (be sure to "click" your way through – everything you need to assist you is in there!), then engage a willing MDA/CRNA and a Surgeon and get to work on a first small test of change.

Let's now work through the process – follow along with the process map.

IDENTIFICATION:

Unlike trying to identify the Heart Failure patient, SCIP VTE2 is much easier – these are folks > 18 years of age, who will be admitted as an inpatient post operatively for an inpatient LOS of greater than or equal to 3 calendar days before being discharged. Understanding the NHQM measure specs (inclusion/exclusions) is imperative. At various points preoperatively, e.g., surgery scheduling, pre-operative assessment /clinic/testing and during anesthesia intake ask " is this patient eligible for VTE/bleeding risk assessment and VTE prophylaxis?" If yes, what's the plan for peri-op VTE prophylaxis? For patient on chronic therapeutic anticoagulation therapy (warfarin), what's the plan for "bridge therapy"? For highest clinical quality and patient safety, always combine VTE risk and bleeding risk assessments together. For bleeding risk – what's the plan for major blood loss and are we prepared?

Other opportunities to IDENTIFY surgical patients eligible for VTE prophylaxis include:

- prior to induction
- during the surgical timeout
- during the post surgical debrief
- at the handoff to PACU
- at the PACU to ICU/receiving unit hand off
- during shift rounds on the receiving unit
- during a review of midnight census and in house post ops
- as 6 am labs are ordered (synchronize VTE prophylaxis with SCIP 4 in appropriate cases.

http://premier.involvetechnology.com/si?iid=15540

Premier Care Process Flow: Evidence Based Care > SCIP > SCIP VTE 2

Surgery pts who received appropriate VTE prophylaxis within 24 hrs prior to surgery up to 24 hours after surgery end time