

Prioritization Worksheet

What is the purpose of this tool? In today’s health care world, hospitals are required to take on more responsibility than ever. With many different competing priorities, senior leaders need to work to prioritize their efforts. With fewer resources than ever before, hospitals need to prioritize where to spend those resources to obtain maximum benefit. Tool C.1, the Prioritization Worksheet, will help your organization determine which Quality Indicators (PSIs, IQIs, and/or PDIs) to focus your resources on. In this tool, the PSIs, IQIs, and PDIs are grouped similarly for easier evaluation. For example, PSIs 17, 18, and 19 are grouped together under the section “Obstetric”.

The Prioritization Worksheet (C.1) has four sections. The first section (blue) will identify which quality indicators (PSIs, IQIs, and/or PDIs) are worse than the comparator set by your institution. The second section (green) will identify the cost implication of each QI for your organization. The third section (purple) will assist your organization in aligning each QI with your organizational strategic initiatives, external mandates your organization must comply with, and public perceptions of your care for each indicator. The fourth section (orange) will give your organization an idea of how likely each improvement initiative is to succeed, based on current barriers.

Organizations do not need to use every section in this tool. For example, if financial information will not be used in the decision process, that section can be left blank. Conversely, if there is additional organization-specific information needed for prioritization, columns can be added (e.g., length of stay, mortality rates, patients harmed).

This tool should be used to guide your decisionmaking process regarding priorities at your organization. The tool does not need to be used to make final decisions but should be used in your prioritization discussion. Ultimately, senior leadership must make the final decision on what should take priority at your organization.

Who are the target audiences? The target audiences for this tool are organization strategic planners, senior clinical leaders, and quality improvement leaders.

How can this tool help you? This tool is designed to help guide your organization’s discussion in determining the direction of organizational focus and decisions about which AHRQ QIs should be addressed during quality improvement initiatives.

How does this tool relate to the others? This tool should be used prior to starting work using the improvement methods tools (Section D). In particular, it can provide information on factors that may be barriers to implementation for use in the *Gap Analysis* (Tool D.5), and outcomes (e.g., cost-effectiveness and volume) could be linked to the *Implementation Measurement* (Tool D.7) and *Project Evaluation and Debriefing* (Tool D.8).

Directions for Using the Prioritization Worksheet

Section 1 - Blue: Own Rate and National Comparator

1. Using section 1 of the worksheet, calculate your organization's performance on each specific PSI, IQI, and/or PDI (using section B of the toolkit); if the data are provided to you by an outside vendor, obtain those data. It is suggested that you use at least a year's worth of data in the tool. Prefill your performance rates for the specified time period into column C, "Own Rate."
2. Determine what your organizational comparator will be. It is up to your organization to determine what you will use as a comparator. Consider using outside comparators, such as those received from vendors, comparators received from national studies, or the targets obtained from running the AHRQ QI software. Refer to Tool B.5 for more information on selecting a comparator. Once you decide on those comparators, fill them into column D, "National Comparators."
3. Once your hospital's specific rates and comparators are set, determine which QIs are worse than the comparator your organization has set. Either check or highlight each box next to the PSIs, IQIs, and/or PDIs that have a rate worse than the comparator. This will help your organization narrow down which PSIs, IQIs, and/or PDIs are a potential issue within your organization.

Section 2 - Green: Estimate Annual Cost and Cost To Implement

For more information about consideration of costs, see the Return-on-Investment (ROI) Tool F.1.

4. In column E, "Volume of Cases at Risk," indicate the annual volume of each PSI, IQI, and/or PDI event occurring within your organization. This number is the total raw number of events occurring within your organization for your chosen time period. Consider highlighting the high-volume indicators on the worksheet to bring those indicators to your attention. Each hospital will need to determine what is considered high volume for them.
5. Column F, "Cost of Single Event," indicates the average cost to your organization of one event. This number is meant to help estimate cost and is not absolute. Each organization will need to determine if this information will be used to prioritize. If so, it is imperative that you bring in members of your finance department to calculate these numbers. We have not included cost estimates for a single event directly in the worksheet, as you may want to consider your own specific costs given variability of costs. If you decide to calculate your own costs using internal data, you may wish to consider the following challenges:
 - Costs versus charges: Wherever possible, strive to use actual costs as opposed to charges (which will typically overestimate cost).
 - Appropriate comparator: When trying to identify the cost attributable to an adverse event captured by your indicator, be thoughtful about which patients will serve as your comparator, meaning the patients *without* the adverse event. Patients who experience adverse events often tend to have more comorbidities and other risk factors and thus have accrued more costs even prior to the adverse event. Therefore, choose a group that did not experience the adverse event that is as comparable as possible to the group that did experience the adverse event and/or adjust for possible factors that could increase both

costs and risk of the adverse event (e.g., concurrent cancer diagnosis). Ideally, if your data permit, you would consider only costs that occur *after* the adverse event occurred.

6. Column G, “Total Cost,” will estimate the total cost of this event to your organization for the chosen time period. To determine this number, for each PSI, IQI, and/or PDI, multiply column E, “Volume of Cases at Risk” by column F, “Cost of Single Event.” The total number should give you an idea of total cost to your organization for each indicator. Consider highlighting those indicators that have a high total cost for your organization. Again, each organization will have to determine on its own what will be considered high cost.
7. Column H, “Cost To Implement,” will determine the anticipated cost in resources, such as supplies, staff time, and facility changes, to implement the improvement initiative compared with the total cost of the event to your organization. With the help of colleagues from the finance department, determine what the cost would be to your organization to implement an improvement project for the high-priority QIs. Compare the total costs of having an adverse event (Column G, Total Cost) with the anticipated cost to implement improvement initiatives (Column H, Cost To Implement). In other words, you are measuring the cost of implementation vs. the cost of not stopping these events. For each indicator, either answer “Yes,” meaning the cost to improve is less than the cost of the event to the organization, or “No,” meaning the cost to improve is more than the cost of the event to the organization.
8. Column I, “Penalties and Incentives,” will estimate institutional penalties and incentives that may accrue depending on performance, such as the Hospital-Acquired Condition Reduction and Value-Based Purchasing Programs. With the help of colleagues from the finance department, estimate the potential financial effects of bringing your institution’s PDIs/PSIs/IQIs in line with national comparators.
9. For column J, “Proxies for Cost,” additional information may be used in addition to or instead of cost estimates in Columns F-I. Examples could include length of stay, additional procedures, readmissions, or patients harmed.

Section 3 - Purple: Rate Strategic Alignment and Regulatory Mandates

10. For column K, “Strategic Alignment,” read the statement and then rate, on a scale of 10-0, how much you agree or disagree that each indicator aligns with your strategic goals, cultural mission, organizational values, and priorities. A 10 indicates that you completely agree that the PSI/IQI/PDI aligns with organizational goals and priorities, while a score of 0 indicates you completely disagree that the PSI/IQI/PDI aligns with the organizational goals, mission, values, and priorities. Your team can go through and rate how well all the PSIs, IQIs, and/or PDIs align with your organization’s strategic goals, mission, values, and priorities and then highlight those indicators that are above a certain number.
11. In column L, “External Mandates,” the same rules apply. On a scale of 10-0, how much do you agree or disagree that each indicator has a high level of external regulatory mandates on your organization. This number should reflect your current situation. Have you been cited in the past by The Joint Commission regarding a certain condition? Are you currently under a Request for Information involving an indicator? Again, consider highlighting those indicators that are above a certain number.
12. In column M, “Public Perception,” rate how much public perception will influence your work on the indicators. Again, each organization will rate this item differently depending on

its situation. Has your organization recently experienced negative press regarding an event? What would this look like in the community if you had an event in your organization? Are you competing for market share that would influence you to focus on a certain indicator? Again, consider highlighting those indicators that are above a certain number.

Section 4 - Orange: Barrier Assessment

13. In each column (N-R), indicate whether your organization agrees with the barrier assessment (see below for further explanation of each category). In those areas marked with a no, your organization will need to address these barriers before an improvement project is started.

Barrier Assessment Categories

Executive-Level Support

Top-level commitment is vital to engendering commitment from those at the front line. If employees do not see that the company's leadership is backing a project, they are unlikely to change.

Staff Capability

Since project teams handle a wide range of activities, resources, pressures, external stimuli, and unforeseen obstacles, they must be cohesive and well led. The team leader must be capable. The team members must have sufficient skills, motivations, and time to spend on the project.

Staff Willingness

It is important to recognize the role that managers and staff will play. By communicating with them early and consistently, senior executives can get employees on board.

Time and Effort

When companies launch transformation efforts, they frequently do not realize or do not know how to deal with the fact that employees are already busy with their day-to-day responsibilities.

Ability To Monitor Progress

The probability that projects will run into trouble rises exponentially when the time between reviews exceeds 8 weeks. Scheduling milestones and assessing their impact are the best way by which executives can review the execution of projects, identify gaps, and spot new risks.