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Letters to the Editor

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100 Patient Safety Benchmarks

By Ellie Rizzo

For hospitals, benchmarking data can be incredibly valuable. It allows individual institutions to identify areas of excellence and assess opportunities for improvement, ultimately resulting in more efficient operations and better care. *Becker's Hospital Review* has compiled a list of 100 patient safety benchmarks from various sources for hospital comparison.

Readmissions, Mortality and Complications

Entries 1 through 20 are based on data from Medicare.gov's Hospital Compare, last updated July 18, 2013.

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9 Best Practices for Implementing Evidence-Based Guidelines

By Ellie Rizzo

Hospital leaders agree: Evidence-based care protocols to guide how care is delivered are becoming the new norm. Putting guidelines in place can improve patient safety, streamline methods of care, lower costs and increase efficiency. Guidelines are especially useful for refining methods of care for high-volume, high-cost or high-risk conditions. The process for guideline implementation, however, can seem daunting, especially when it requires a large number of physicians from various specialties to agree to a single set of guidelines. However, the payoff can be better care and reduced variation — two major goals for healthcare providers. Here are nine best practices for working with evidence-based guidelines at all stages of the process.

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4 Tips to Implement a Transparent Medical Error Disclosure Policy

By Sabrina Rodak

Ann Arbor-based University of Michigan Health System has been widely recognized for its innovative medical error disclosure policy called the Michigan Model. In the case of an error or complaint, a team of professionals analyzes the situation to determine the cause of an event. If the team determines there was a medical error or care was inappropriate, the providers apologize and work with the patient to reach a joint solution. If the team determines care was medically appropriate, UMHS explains the case to the patient and defends its providers.

Since UMHS began this approach in 2001, the number of pre-suit claims and pending lawsuits dropped approximately 61.5 percent. In addition, UMHS decreased its average legal expense per case by more than 50 percent since 1997, including a savings of $2 million in the first year alone of the Michigan Model.

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1,2,3,4,5,6 References available at purthread.com/references/
The EPA has not reviewed PurThread data for healthcare claims.

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FEATURES

100 Patient Safety Benchmarks (continued from page 1)

30-Day average readmissions rates
1. Heart attack: 19.7%
2. Heart Failure: 24.7%
3. Pneumonia: 18.5%

30-Day average death rates
4. Heart attack: 15.5%
5. Heart Failure 11.6%
6. Pneumonia: 12.0%

Rates of serious complications

Figures reflect the national average rates per 1,000 patient discharges.
7. Collapsed lung due to medical treatment: .35
8. Serious blood clots after surgery: 4.71
9. A wound that splits open after surgery, abdomen or pelvis: .95
10. Accidental cuts and tears from medical treatment: 2.05
11. Deaths among patients with serious treatable complications after surgery: 113.43

Hospital acquired conditions

Figures reflect the national average rates per 1,000 patient discharges.
12. Objects left in body accidently after surgery: 0.028
13. Air bubble in the bloodstream: 0.003
14. Mismatched blood types: 0.001
15. Severe pressure sores: 0.136
16. Falls or other injuries: 0.527
17. Blood infection from large-vein catheter: 0.372
18. Urinary catheter infection: 0.358
19. Uncontrolled blood sugar signs: 0.058

Entries 20 through 34 are based on data from AHRQ's Hospital Survey on Patient Safety Culture 2012, where data was collected from individual respondents at 1,128 hospitals.

20. Respondents reporting no events in the past 12 months:
10th percentile: 42%
25th percentile: 48%
Median: 55%
75th percentile: 62%
90th percentile: 68%
Average: 55%

21. Respondents reporting 1-2 events in the past 12 months:
10th percentile: 19%
25th percentile: 23%
Median: 27%
75th percentile: 31%
90th percentile: 35%
Average: 27%

22. Respondents reporting 3-5 events in the past 12 months:
25th percentile: 19%
Median: 11%
75th percentile: 14%
90th percentile: 17%
Average: 12%

23. Respondents reporting 6-10 events in the past 12 months:
10th percentile: 2%
25th percentile: 3%
Median: 4%
75th percentile: 5%
90th percentile: 7%
Average: 4%

24. Respondents reporting 11-20 events in the past 12 months:
10th percentile: 05
25th percentile: 1%
Median: 1%
75th percentile: 2%
90th percentile: 3%
Average: 2%

25. Respondents reporting 21 or more events in the last 12 months:
10th percentile: 0%
25th percentile: 0%
Median: 1%
75th percentile: 1%
90th percentile: 2%
Average: 1%

Percentage of units reporting patient safety events in the last 12 months:
26. Anesthesiology
No Events: 56%
1-2 Events: 31%
3-5 Events: 10%
6-10 Events: 3%
11+ Events: 0%

27. Emergency
No Events: 48%
1-2 Events: 31%
3-5 Events: 13%
6-10 Events: 5%
11+ Events: 1%

28. Intensive Care Unit (any type)
No Events: 36%
1-2 Events: 39%
3-5 Events: 17%
6-10 Events: 5%
11+ Events: 1%

29. Obstetrics
No Events: 46%
1-2 Events: 35%
3-5 Events: 13%
6-10 Events: 4%
11+ Events: 0%

30. Pediatrics
No Events: 45%
1-2 Events: 35%
3-5 Events: 14%
6-10 Events: 4%
11+ Events: 0%

31. Pharmacy
No Events: 46%
1-2 Events: 20%
3-5 Events: 15%
6-10 Events: 9%
11+ Events: 1%

32. Radiology
No Events: 56%
1-2 Events: 32%
3-5 Events: 9%
6-10 Events: 3%
11+ Events: 0%

33. Rehabilitation
No Events: 60%
1-2 Events: 30%
3-5 Events: 7%
6-10 Events: 2%
11+ Events: 0%

34. Surgery
No Events: 47%
1-2 Events: 32%
3-5 Events: 14%
6-10 Events: 5%
11+ Events: 1%

Process of Care Measures

Entries 35 through 79 are based on data from Medicare.gov's Hospital Compare, last updated July 18, 2013. Percentages below reflect the national average.

Heart attack/chest pain patient data

35. Average number of minutes before chest pain/heart attack patient was transferred to another hospital if he or she needed specialized care: 58 minutes

36. Average number of minutes before chest pain/heart attack patient got an ECG: 7 minutes

37. Percentage of chest pain/heart attack patients who got drugs to break up clots within 30 minutes of arrival: 58%

38. Percentage of chest pain/heart attack patients who got aspirin within 24 hours of arrival: 97%

39. Percentage of chest pain/heart attack patients who were given fibrinolytic medication within 30 minutes of arrival: 61%

40. Percentage of chest pain/heart attack patients who were given percutaneous coronary intervention within 90 minutes of arrival: 95%

41. Percentage of Heart Attack Patients given Asprin at discharge: 99%

42. Percentage of Heart Attack Patients given a prescription for Statin at discharge: 98%

43. Percentage of Heart failure patients given discharge instructions: 95%

44. Percentage of heart failure patients given an evaluation of left ventricular systolic function: 99%

45. Percentage of heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction: 97%

Pneumonia patient data

46. Percentage of pneumonia patients whose initial emergency room blood culture was performed before antibiotic administration: 98%

47. Percentage of pneumonia patients given most appropriate initial antibiotics: 94%

Surgery patient data

48. Percentage of outpatients who got an antibiotic within one hour of surgery: 97%

49. Percentage of patients given an antibiotic to help prevent infection within an hour of surgery: 98%

50. Percentage of patients whose preventive antibiotics were stopped within 24 hours of surgery: 97%

51. Percentage of patients who got treatment within 24 hours before or after surgery to help prevent blood clots after certain types of surgery: 98%

52. Percentage of outpatients who got the right kind of antibiotic: 97%

53. Percentage of patients taking beta blockers kept on the beta blockers just before and after surgery: 97%

54. Percentage of patients given the right kind of antibiotic to prevent infection: 99%

55. Percentage of heart surgery patients whose blood glucose was well controlled in days immediately after surgery: 96%

56. Percentage of patients whose urinary catheters were removed on the first or second postsurgical day: 96%

57. Percentage of patients actively warmed in operating room or whose body temperature was near normal by the end of surgery: 100%

58. Percentage of patients whose physician ordered treatments to prevent blood clots after certain types of surgeries: 98%

Emergency department patient data

59. Average time spent in the emergency department before being admitted as an inpatient: 274 minutes

60. Average time spent in the emergency department after doctor decided to admit them as an inpatient before moving from emergency department to inpatient room: 96 minutes

61. Average time spent in the emergency department before being sent home: 138 minutes

62. Average time spent in the emergency department before being seen by a healthcare professional: 28 minutes

63. Average time spent with broken bones waited before receiving pain medication: 60 minutes

64. Percentage of patients who came to the emergency room with stroke symptoms and received brain scan results within 45 minutes of arrival: 46%

65. Percentage of patients assessed and given influenza vaccination: 86%

66. Percentage of patients assessed and given pneumonia vaccination: 88%

Pediatric asthma data

67. Percentage of children who received reliever medication while hospitalized for asthma: 100%

68. Percentage of children who received systemic corticosteroid medication while hospitalized for asthma: 100%

69. Percentage of children and caregivers who received a home management plan of care document while hospitalized for asthma: 86%

Patient Experience

Percentage of patients reporting that something was "always" done during their hospital stays:

70. Nurses communicated well: 78%

71. Physicians communicated well: 81%

72. Patients received help as soon as they wanted: 67%

73. Pain was well controlled: 71%

74. Staff explained medicines before administration: 63%

75. Room and bathroom were clean: 73%

76. Area around patient room was quiet at night: 60%

77. Information was given to patients about what to do at home during recovery: 84%

78. Patients rated their hospital a 9 or 10 (10 being the highest): 70%

79. Patients reported they would recommend their hospital: 71%

Patient Volumes

Entries 80 through 83 are from the Kaiser Family Foundation's State Health Facts

80. Number of hospital admissions

Average per 1,000 population
State/locally owned: 15
Nonprofit: 83
For-Profit: 16

81. Number of hospital inpatient days

Average per 1,000 population
State/locally owned: 95
Nonprofit: 434
For-Profit: 84

82. Hospital emergency room visits

Average per 1,000 population
State/locally owned: 65
Nonprofit: 291
For-profit: 55

83. Hospital outpatient visits

Average per 1,000 population
State-locally owned: 352
Nonprofit: 1,597*
For-profit: 156
**This statistic reflects multiple visits per individual*

Patient Safety Culture

Entries 69 through 100 are based on data from AHRQ's Hospital Survey on Patient Safety Culture 2012.

84. Percentage of hospital staff reporting teamwork within units:

10th percentile: 73%
25th percentile: 76%
Median: 80%
75th percentile: 84%
90th percentile: 87%
Average: 80%

85. Percentage of hospital staff reporting supervisor/manager expectations and actions promoting patient safety:
10th percentile: 67%
25th percentile: 71%
Median: 75%
75th percentile: 79%
90th percentile: 83%
Average: 75%

86. Percentage of hospital staff reporting organizational learning and continuous improvement from mistakes:
10th percentile: 63%
25th percentile: 68%
Median: 72%
75th percentile: 77%
90th percentile: 81%
Average: 72%

87. Percentage of hospital staff reporting management support for patient safety:
10th percentile: 61%
25th percentile: 67%
Median: 72%
75th percentile: 77%
90th percentile: 81%
Average: 72%

88. Percentage of hospital staff reporting overall perceptions of patient safety:
10th percentile: 56%
25th percentile: 60%
Median: 66%
75th percentile: 71%
90th percentile: 76%
Average: 66%

89. Percentage of hospital staff reporting feedback and communications about errors:
10th percentile: 55%
25th percentile: 59%
Median: 64%
75th percentile: 70%
90th percentile: 74%
Average: 64%

90. Percentage of hospital staff reporting frequency of events that had potential to cause harm but did not cause harm and were reported:
10th percentile: 54%
25th percentile: 58%
Median: 62%
75th percentile: 66%
90th percentile: 68%
Average: 63%

91. Percentage of hospital staff reporting communication and openness:
10th percentile: 54%
25th percentile: 58%
Median: 62%
75th percentile: 66%
90th percentile: 69%
Average: 62%

92. Percentage of hospital staff reporting teamwork across units:
10th percentile: 47%
25th percentile: 52%
Median: 58%
75th percentile: 64%
90th percentile: 72%
Average: 58%

93. Percentage of hospital staff reporting adequate unit staffing to provide quality care:
10th percentile: 45%
25th percentile: 50%
Median: 56%
75th percentile: 62%
90th percentile: 68%
Average: 56%

94. Percentage of hospital staff reporting smooth informational handoffs & care transitions:
10th percentile: 33%
25th percentile: 38%
Median: 44%
75th percentile: 52%
90th percentile: 60%
Average: 45%

95: Percentage of hospital staff reporting nonpunitive response to error:
10th percentile: 34%
25th percentile: 38%
Median: 43%
75th percentile: 48%
90th percentile: 54%
Average: 44%

96. Percentage of hospital staff giving their hospital an "excellent" patient safety grade:
10th percentile: 19%
25th percentile: 23%
Median: 29%
75th percentile: 35%
90th percentile: 42%
Average: 30%

97. Percentage of hospital staff giving their hospital a "very good" patient safety grade:
10th percentile: 19%
25th percentile: 23%
Median: 29%
75th percentile: 49%
90th percentile: 54%
Average: 45%

98: Percentage of hospital staff giving their hospital an "acceptable" patient safety grade:
10th percentile: 12%
25th percentile: 15%
Median: 20%
75th percentile: 24%
90th percentile: 29%
Average: 20%

99: Percentage of hospital staff giving their hospital a "poor" patient safety grade:
10th percentile: 2%
25th percentile: 3%
Median: 5%
75th percentile: 5%
90th percentile: 7%
Average: 4%

100: Percentage of hospital staff giving their hospital a "failing" patient safety grade:
10th percentile: 0%
25th percentile: 0%
Median: 0%
75th percentile: 1%
90th percentile: 2%
Average: 1% ■

9 Best Practices for Implementing Evidence-Based Guidelines

(continued from page 1)

1. Let physicians lead the charge. Successful guidelines start with those who provide care, and the most successful programs for implementing evidence-based quality measures rely heavily on clinician participation. Barton Hill, MD, vice president and chief quality officer at St. Luke's Health System in Boise, Idaho, can attest to the importance of the individual clinician in evidence-based medicine. He believes that St. Luke's success with implementing evidence-based guidelines is in large part due to clinicians with a vision of a hospital that practices in the best way it can. "It begins with one person having a passion and making a change," he says.

Oscar Marroquin, MD, director of provider analytics and a cardiologist at University of Pittsburgh Medical Center, agrees. "Physicians are the ones who are going to decide whether we are utilizing our resources in the right way. They have to be at the table, because in our experience, if guidelines are physician-led and guideline content is developed by physicians, we're more likely to succeed."

2. Start small. Adopting evidence-based medicine doesn't have to be an insurmountable undertaking. Dr. Hill's best advice for hospitals looking to start evidence-based quality programs is to start small: Pick one or a few guidelines to investigate and implement, pilot the program results and clearly demonstrate program benefits. Choosing low-hanging fruit right out of the gate is a fine way to start, as it piques interest in evidence-based medicine and demonstrates the value of evidence-based quality guidelines, he says. If the going gets tough, Dr. Hill recommends keeping the ultimate goal of patient safety in mind. "What we want for ourselves and our family — that's the litmus test," says Dr. Hill. "You live in that community, and we all will be patients at some point."

3. Embrace transparency. "Transparency during the guideline creation process is very important. We help everyone understand reasons behind a guideline so they can discuss it and have access to it after it's completed," says Val Slayton, MD, vice president of El Segundo, Calif.-based The Camden Group, a healthcare consulting firm. Ensuring clinicians understand the actual evidence that supports guidelines is also a must. "Providing a rating system for guidelines can help clinicians understand how strong the evidence is," suggests Dr. Slayton.

"We disseminate the guidelines among our clinicians for comment, inviting them to participate in the creation even if they are not a member of the team that created or designed them. If they want a change made, we ask them to support it with evidence from medical literature," says Helen Macfie, PharmD, senior vice president of performance improvement at California-based MemorialCare Health System.

Dr. Hill agrees sharing progress with physicians is important. "One of the keys to success is being transparent. Sharing makes others intrigued and excited and makes people think that progress is worth the discomfort of change," he says.

4. Communicate, communicate and communicate some more. When it comes to evidence-based guidelines, it's impossible to communicate too much. "Sharing results and best practices with our associates creates a smooth process for implementation," says Leslie Simmons, RN, FACHE, president of Westminster, Md.-based Carroll Hospital Center. "For instance, connecting the dots for physicians and staff and showing how following guidelines improve results is vital." According to Mrs. Simmons, Carroll Hospital Center's persistent communication with its staff has been instrumental in eliminating ventilator-related pneumonia for the last four years and central line infections in critical care units the last three years.

It's not always easy, however. "Awareness and communication are always a challenge," says Patricia Davis-Hagens, RN, chief nursing officer and vice president of nursing and site administrator at Mercy Health's Fairfield (Ohio) Hospital. She recommends trying different modes of communication to attract different demographics of healthcare providers. "Younger employees gravitate towards our electronic bulletin boards, though paper boards seem to work with our more tenured employees," she says. Finding alternate ways to present communication can also be useful. Fairfield Hospital had particular success in reducing patient falls when it personalized fall data to the patient population and publicly displayed information pertaining to the quality goal at hand, including the number of days since the last fall had occurred.

Tim Hannon, MD, MBA, an anesthesiologist and the founder of Indianapolis-based Strategic Healthcare Group, a company devoted to improving blood management, agrees: "It is possible to accelerate the guideline process by being smart, targeting appropriately, communicating, then over-communicating."

5. Add a 'why' to every 'what.' Healthcare providers are smart and motivated and will almost certainly have questions about the necessity of a change. If a compelling rationale is readily available, the guideline process becomes a productive open dialogue. Not every clinician will respond similarly, however. In Dr. Hannon's experience both as an internal physician champion and as an outside consultant, between 15 and 20 percent of physicians will either strongly support or strongly reject a guideline. The other 65 percent are the ideal target population for education. "Allow supporters to be vocal, educate those who are on the fence, and initially resistant clinicians may begin to participate in the change," he says, noting that this bandwagon approach seems particularly effective.

6. Experiment with customization for best results. Just because a guideline exists does not mean it is right for every scenario. Identifying guidelines with potential caveats and working out a strategy to remind clinicians of possible variations is crucial. "There are times when guidelines should not be followed, given the unique patient's condition. We work to identify those up front and build them right into our online guidelines to make it easy for the clinician to document those exceptions," says Dr. Macfie of MemorialCare.

Another place where customization is crucial is in presenting guidelines: Each hospital must discover which type of presentation works with its staff. Ms. Davis-Hagens shared a particularly compelling example of a successful quality customization. Fairfield Hospital had a guideline for VTE prophylaxis in place, but quality administrators consistently documented less than 50 percent compliance. Physicians were simply forgetting to follow a well-accepted guideline.

"Now that guideline is integrated to our electronic health record system. When we first made a hard stop in the physician order with the guideline, we got to 100 percent compliance within three weeks," Ms. Davis-Hagens says.

7. Consider cost. True evidence-based care does not measure cost at all," notes Dr. Hill. Having infinite resources for providing the best possible care would be ideal, but it is unfortunately never the case. As hospitals increasingly move to value-based payments, physicians will need to examine if a generic drug or lower cost supply can provide similar outcomes at a lower cost. "Ultimately, there will be some trade-offs between better population health outcomes, better care outcomes and lower costs," Dr. Hill says. The trick is deciding how these trade-offs apply for every guideline according to an individual center's institutional goals. Happily for all, it is not unusual for better, more efficient care to go hand-in-hand with lower costs.

8. Ensure guidelines are updated regularly. Even if it's a job well done, the work isn't over once a guideline is in place. "Guidelines must be revisited maybe every year or two to make sure evidence has kept up. You have to keep your guidelines current," says Dr. Slayton of The Camden Group. To maintain and advance quality gains from evidence-based guidelines, hospitals must institute a system for consistent guideline review. Many healthcare centers do this with multiple committees of stakeholders responsible for the upkeep of one or a few guidelines.

9. Show institutional support from leadership. Make commitment to evidence-based guidelines part of the institutional DNA. The bot-

tom line is that evidence-based guidelines eliminate variations in care and give patients the best results scientific evidence can provide. The process is an incredibly collaborative one, and as such it requires robust support from administrators so it can take root, grow and flourish. Among other things, it requires effective administrative mediators and explicit support for clinicians and staff in quality-improvement endeavors. It's no secret, Dr. Marroquin of UPMC says, that getting consensus from groups of different physicians can sometimes be astonishingly difficult. The administrator's role is to embrace the opportunity to sit in the middle and facilitate the process of reaching an agreement. "Leadership at highest level must say 'this is important, we are going to do this, and we are going to transform ourselves,'" he says.

Institutional support goes beyond mediation, however. Hospitals and hospital systems should strive to establish long-term goals guiding quality improvements. Among hospitals represented here, MemorialCare Health System has instituted safety goals informing the system's patient-centered philosophy on treating conditions with high rates of mortality, frequency or complication. St. Luke's has made a quality-minded triple commitment to be physician-led, have an infrastructure of physician leaders and practice evidence-based medicine where it exists. Carroll Hospital Center not only supports quality improvement within its own institution, but also makes an effort to participate in every Maryland statewide collaborative contributing to research supporting guidelines and best practices in guideline implementation.

Hospital leadership can make permanent quality gains from evidence-based guidelines a reality when it supports its clinicians in improving quality, facilitates discussions among interested parties makes a commitment to try, reform and maintain guidelines and institutes norms of evidence-based practice. ■

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4 Tips to Implement a Transparent Medical Error Disclosure Policy
(continued from page 1)

What disclosure is really about: Safe patient care

While these results are impressive, the true value of the program is in higher quality and safer care, according to Rick Boothman, JD, chief risk officer of UMHS. "It is important to understand that our approach is not just about achieving savings in claims; at the heart of our approach is a deep commitment to learning from our mistakes and improving the quality of our care," he says. "Transparency is not just a strategy for handling claims. The core value of transparency is that it is absolutely necessary if we're going to improve the quality of medical care."

Replicating the Michigan Model

Here are some tips to implement a transparent medical error disclosure policy in a hospital or health system.

1. Communicate the benefit to providers. Being honest with patients about medical complications, whether due to a provider error or not, benefits both patients and providers. When a mistake is made, being honest with a patient enables providers to learn from their error. When providers did not make a mistake, acknowledging this fact instills confidence in them.

Being honest with patients can also save providers from needless litigation — an outcome opposite of many people's expectations, according to Mr. Boothman. "We didn't open a floodgate of claims by admitting we've had our own share of problems," he says.

2. Designate a physician advocate. Hospitals should designate a leader in the risk management department to be a physician advocate to encourage openness. "I have never advertised myself as a patient's advocate," Mr. Boothman says. "I know what I'm doing directly benefits patient care and patients, but it's important for me to say to staff, 'I'm here for you.'" Having someone to support providers through the disclosure process is critical for building trust with providers and encouraging openness.

3. Ease others' fears. One of the biggest challenges to implementing a transparent disclosure policy is resistance from people who feel their job is threatened by a new approach to medical errors and malpractice, according to Mr. Boothman. Hospitals' defense lawyers are typically the most resistant to this change, possibly because they believe their job may not fit in the new model, he says. "The industry, which has been built around a deny-and-defend mentality, is very threatened by this. But if our heart is in the right place and we want to do the right thing by our clients — doctors and hospitals — [the transparent approach] makes too much sense," he says.

4. Consider the role of insurance. UMHS is self-insured for malpractice insurance, which, while not a requirement for its disclosure model, does make the policy easier to implement, according to Mr. Boothman. First, being self-insured guarantees that the malpractice claims policy aligns with a goal of quality care. "An independent insurance company does not have the same interest that a self-insured institution like ours would have in terms of an abiding interest in quality of care," Mr. Boothman says. In addition, being self-insured eliminates the challenges associated with working with an outside company. "We don't have another corporate voice to deal with," he says.

Committing to medical error transparency

Ultimately, committing to transparency with medical complications and errors is critical to improving quality and patient safety, and has the added benefit of potential savings in reduced malpractice claims. Being honest with patients

builds trust and strengthens the relationship between patients and providers. "[Malpractice challenges] are never going to get better until we embrace the notion that all parties — patients, families and caregivers — are in this together," Mr. Boothman says. ■

MORE ONLINE:

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Letting Physicians Take the Lead: Q&A With Scripps Health CMO Dr. James LaBelle

By Molly Gamble

James LaBelle, MD, was named corporate senior vice president and CMO of San Diego-based Scripps Health in January 2013. As a physician who practiced emergency medicine for more than 25 years, Dr. LaBelle now leads Scripps' 2,600 affiliated physicians and helps drive systemwide efforts to cut unnecessary variation and costs while maintaining quality. It's a balancing act, and some of the hardest work Dr. LaBelle says he's ever encountered — but the work also comes with great rewards.

Cost-cutting is nothing new to five-hospital Scripps. For the past three years, the system has implemented performance improvements that totaled $77 million in savings for fiscal year 2011 and $64 million in fiscal year 2012. This year, Scripps hopes to save $66 million through new clinical initiatives, redesigned operational processes and workforce development.

More and more, Scripps physicians are leading these efforts and making important decisions on how to improve care delivery. The system has formalized eight clinical care lines, led by groups of physicians, for its main specialties to reduce unnecessary variation in care. Recently, it has also implemented a cardiovascular surgery initiative, in which surgeons identified best practices for diagnosis-related groups. Within one year, Scripps reduced the average length of stay for cardiac surgery patients by 0.8 days.

Here, Dr. LaBelle discusses his first six months as CMO of Scripps, how he views the emerging role of prices in healthcare and how he empowers physicians to take charge of improvements within the system.

Question: As someone who has served in the CMO role for a short amount of time, is there any advice you'd share with someone who was about to assume the CMO role with his/her health system? What are some lessons you've learned since January?

Dr. LaBelle: It's been the most challenging job I've ever had but also the most rewarding. I've never worked this hard in my life, with the exception of my internship, and that was in the time of 80- to 90-hour work weeks. It's a hard job.

I think the rewards, in terms of understanding and influencing policy and driving change, are profound and deep. They allow you to touch not just one patient at a time, serially, but multiple patients over time throughout San Diego County. I find two emotions from that: One is just a profound honor. The other is this scary obligation to get it right.

There is absolutely stuff that keeps me up at night. [We are] guiding the health system in a time of profound transition, and [must ensure] that transition is done without damage to the health system and its physicians. But most important is making sure we've maintained a safe health system that meets the quality expectations we hold for Scripps.

There have been a number of structural things we've done in the quality department. We spent a great deal of time to put in controls and monitors as we drive change, so there are deep, robust mechanisms monitoring clinical process performance and elevating risks to the appropriate level in a timely fashion. If I was a CMO coming in [to a new organization], I'd spend great time on due diligence in risk detection at that organization. The biggest risks are going to be clinical risks to patients.

Q: It sounds like, more and more, physicians are taking the lead in Scripps' integration efforts, as well as those to boost quality and cut costs. How have you empowered physicians to take the reins with these initiatives?

JL: Health systems that haven't been able to develop physician leadership — or give smart people the same information so they can come to the same conclusions — will be at a competitive disadvantage. Those systems that partner with doctors in decision-making and go through the hard journey of letting up control and trusting physicians as full partners will make early decisions around consolidation of services and [reap] not only financial rewards, but quality rewards that will drive volume in the future.

Q. What is your personal leadership style like with physicians? How do you empower them?

JL: Physicians are like everybody else. You have to invest in them and support them as they develop their ability to lead. It's important that you have a group, not just individual physicians, committed to developing others.

It's really important to understand a lot of physicians who haven't been fully developed don't have capabilities to lead alone. They need additional help or support as they develop their leadership style in meetings and as they learn from mistakes. The expectation shouldn't be, "These physicians will lead and learn lessons without making mistakes."

We have an investment in our physicians through our Scripps Physician Leadership Academy. It's a cohort of 60 physician leaders who meet monthly to work through some skills of leadership development, strategic planning, vision and marketplace [trends]. They translate those skills into tasks they [face] in medical group leadership roles, medical staff, system leadership roles and other leadership roles they're interested in. I think that's essential. You must have a well-developed physician leader [and] they have to learn how to think strategically.

Q: What about Scripps helps set it apart from other organizations in terms of physician engagement?

JL: I came into [the CMO role as a] partner with a CEO who had a deep philosophy around partnering with physicians. It's an interesting story, in that in talking to people, he's been that way his entire career. But it came to a head a dozen years ago when there was a vote of no confidence, and the former CEO of Scripps was asked to leave.

Chris Van Gorder came into the role and established our Physician Leadership Cabinet, where every important decision is aired in a spirit of partnership with complete transparency with CEOs from each hospital, the CEO of the system and medical staff leadership. That's set the tone for partnerships with physicians for leadership within the system. It's not new since I've been here. I've been the beneficiary of that philosophy. But it's funny how the right person for the right crisis [can have such an] impact for the organization and create a legacy. ■

A Revenue Leak Soon Turns to Flood: How Payment Penalties for High Infection Rates Could Drain Hospital Finances

By Adam A. Boris, CEO, ICNet Systems

As a host of new government payment penalties and reporting requirements take effect, preventing healthcare-associated infections is becoming a matter of financial survival for hospitals. HAIs put millions of dollars in revenue at risk, threaten hospital reputations and tax already limited infection prevention resources.

Accounting for all of the Medicare payment reforms related to HAIs, as well as the costs of extended stays to treat infections, a hospital with $50 million in annual Medicare inpatient revenue would have a potential of $4.82 million in reimbursement at risk this year; that risk will grow to approximately $6.6 million by the fall of 2014 (see chart). Those figures do not take into account Medicaid and private payer actions, which are growing in intensity. Nor do they reflect the significant costs of litigation arising from infections.

With 39 percent of hospitals running at a financial loss in 2011, even a small change to reimbursement rates can lead to huge changes in staffing models at hospitals and ultimately the quality of patient care they are able to provide, the American Hospital Association says.

HAIs cause longer lengths of stay and more intensive care, accounting for $40 billion in excess costs in 2009, according to the Centers for Disease Control and Prevention. For example, treating a central line-associated bloodstream infection adds an average of $36,441 to a hospital bill. All of these costs are absorbed by the hospital's operating budget, as most post-infection care will not be reimbursed.

As a result of these pressures, many senior leaders are looking at new ways of preventing infections, including screening new patients and adopting surgical checklists, stronger isolation precautions and electronic surveillance of potential infections.

HAIs and Payment Penalty Calculator

For a 250-bed hospital, with 2013 Medicare inpatient PPS reimbursement of $50 million

Fiscal year 2013		
Program	**% payment at risk**	**$ at risk**
Infection reporting to NHSN	2%	$1 million
Value-Based Purchasing	1%	$500,000
Readmissions	1%	$500,000
Nonpayment for HAIs*	NA	$20,000
Total payment at risk:		**$2,020,000**
Cost of extended stay due to HAI**		**$2,800,000**
Total direct costs and penalties		**$4,820,000**

Fiscal year 2015		
Program	**% payment at risk**	**$ at risk**
Infection reporting to NHSN	**2%**	$1 million
Readmissions	**3%**	$1.5 million
Bottom quartile of infections:	**1%**	$500,000
Value-Based Purchasing	**1.5%**	$750,000
Nonpayment for HAIs*	**NA**	$20,000
Total payment at risk:		**$3,770,000**
Cost of extended stay due to HAI**		**$2,800,000**
Total direct costs and penalties		**$6,577,000**

* Based on total withhold in fiscal year 2012 divided by number of U.S. hospitals subject to payment penalties

** Assumes 10,000 admissions, 4 percent HAI rate and seven days of extended stay per HAI; internal cost of additional patient day assumed to be $1,000

A continuing threat

The contagion in America's hospitals is far from being under control. In fact, emerging threats from multidrug-resistant organisms and continuing problems in controlling surgical site and catheter-related infections have, if anything, made the problem more dire.

There is evidence that public reporting and payment reforms have had a positive, but limited, effect. A report issued by the CDC in early 2012 found that in 2010 healthcare facilities complying with mandatory infection data reporting to the CDC's National Healthcare Safety Network had 32 percent fewer central line-related infections, 6 percent fewer catheter-related infections and 8 percent fewer surgical site infections than expected based on the case mix of patients and locations monitored.

"The mandatory reporting and in some cases public reporting of HAIs has seemed to elevate the importance of infection prevention in hospitals and often resulted in increased attention by the C-suite on the roles, responsibilities and data collected by infection preventionists and hospital epidemiologists," says Patricia W. Stone, a professor of health policy and director of the Center for Health Policy at Columbia University School of Nursing, who has written extensively on HAIs and reimbursement.

Although there has been a reduction in those infections that have been systematically measured and reported, many common infections persist and are increasing in prominence. The reported infections, such as methicillin-resistant Staphylococcus aureus and central line-related bloodstream infections, are but a small fraction of all infections that occur in a hospital each year. Norovirus, a pathogen that often causes food poisoning and gastroenteritis, is the fastest-growing infection and was responsible for nearly one in five infection outbreaks and 65 percent of unit closures in U.S. hospitals during a two-year period, according to a study published in the February 2012 issue of the *American Journal of Infection Control*.

The high price of inaction

One reason for that failure may have been an unintended consequence of government payment policies, which initially focused attention on a few HAIs. Since 2008, Medicare has refused to pay the added cost of treating catheter-associated urinary tract infections and central line-related bloodstream infections, a policy since extended to surgical site infections following coronary artery bypass grafts, bariatric surgeries and orthopedic procedures.

A Harvard study published in the *New England Journal of Medicine* in October 2012 found no evidence that the Medicare non-payment policy had any measurable effect on infection rates in the U.S. One issue blunting the impact of the law is that hospitals can continue to bill for not only the diagnosis present on admission, but also comorbidities for infected patients. In fact, CMS has admitted that nationally only about $50 million to $60 million has been withheld each year from hospital reimbursements.

"If you think about that amount of money spread across 5,000 or 6,000 facilities, hospitals haven't had a lot of skin in this game, but the no-pay rule did get people's attention because it was the first time there were any payment ramifications related to quality," says Ed Septimus, MD, a professor of internal medicine at Texas A&M Health Science Center in Houston, who previously ran infectious disease programs at Memorial Hermann Healthcare System.

Newer payment penalties, however, are rapidly changing the picture, making a focus on a few infections all but impossible for institutions seeking to retain full payment under Medicare. The Patient Protection and Affordable Care Act introduced the Hospital Inpatient Value-Based Purchasing Program, the Readmissions Reduction Program and a new withholding program for adverse events. The law also broadened the Inpatient Hospital Quality Reporting Program, with more data required to be reported through the National Healthcare Safety Network.

Value-Based Purchasing began in earnest in October 2012 with a 1 percent withhold of baseline DRG payments (the potential penalty will rise to 2 percent by 2016). To earn back a portion or all of the withhold, hospitals must perform well on a combined score based on clinical quality indicators and patient satisfaction measures. For fiscal year 2013, 70 percent of the score is composed of clinical process measures, including several related to infections.

In all, for fiscal year 2013 Medicare is rewarding 1,557 hospitals with more money and reducing payments to 1,427 others, according to CMS data.

The VBP program will be even more painful for hospitals when "double jeopardy" kicks in. Beginning in October 2014, another 1 percent penalty on all Medicare payment will be assessed for hospitals in the bottom quartile of all healthcare-associated conditions — the so-called "never events" that include HAIs — doubling down on the nonpayment rule.

"Once you are in it, you might not ever get out of that quartile," Mr. Septimus notes. All hospitals will be racing to improve, using many of the same best practices, such as the Keystone initiative in Michigan, which dramatically reduced central line-related infections in that state's hospitals.

Readmissions

Under a policy that began to take effect Oct. 1, 2012, hospitals with high rates of 30-day readmissions are subject to a payment penalty, withthose with excess readmissions are penalized 1 percent of baseline MS-DRG payment. That maximum penalty will rise over two years to 3 percent.

In the first year of the program, 2,217 hospitals, or 63.4 percent received penalties for having too many readmissions, and 307 hospitals received the maximum 1 percent penalty.

Post-discharge infections are one of the leading causes of readmissions, especially for surgical patients, studies show.

Hospital patients with a positive clinical culture for MRSA, vancomycin-resistant enterococci or Clostridium difficile are 40 percent likelier to be readmitted within a year than other patients, said a study in the June 2012 issue of *Infection Control and Hospital Epidemiology.*

"By 2014 to 2015 we will really see for the first time a real change in reimbursement based on hospital performance on these measures," Mr. Septimus says. "A few percentage points of revenue adds up to some real financial pressure if you do not perform to a certain level for these reportable conditions."

Payment reform is hardly limited to Medicare. Starting July 1, 2012, the PPACA prohibited federal Medicaid matching funds to states for payments attributed to care provided for the same conditions as the Medicare nonpayment rule.

Reporting concerns

Since January 2011, hospitals participating in the Hospital Inpatient Quality Reporting Program have had to report central line-related infections to the National Healthcare Safety Network or risk loss of 2 percent of baseline Medicare payment. In 2012, the program expanded to cover urinary tract infections and infections from inpatient colon and abdominal hysterectomy surgeries.

Beginning in January 2013 inpatient acute-care facilities must report MRSA and C. difficile infections to NHSN.

Reporting data to NHSN has become a full-time job for many infection preventionists. Hospitals must report not only infections, but also all procedures covered by those codes so the CDC can establish baseline rates of infections. Data about each infection event and each surgical procedure must be entered individually, a process that involves inputting or selecting multiple fields. Manual data entry also increases the opportunity for mistakes, a critical factor, as just one data entry error could jeopardize the successful submission of all data entered.

"Many infection control departments are stretched with various mandatory reporting requirements, including the federal, state and perhaps the local Quality Improvement Organization and/or The Joint Commission," Ms. Stone of Columbia says. "Many clinicians have reported that this takes away time from general prevention activities such as education and patient follow-up, as well as from important (infection-related) problems."

To effectively manage the myriad metrics and reporting requirements and their resulting penalties and costs, Ms. Stone says that hospitals need to invest in appropriate resources to ensure they can reliably set objectives for HAI reduction and measure their performance against those objectives. ■

Adam Boris, MS, MBA, was appointed CEO of ICNet Systems in 2011. He has more than 25 years' experience in leadership positions with various U.S.-based technology companies. ICNet's infection surveillance software helps more than 1,000 hospitals around the world reduce surgical site infections, prevent outbreaks and adverse drug events, and facilitate antimicrobial stewardship.

5 Strategies to Combat Antibiotic-Resistant Bacteria

By Sabrina Rodak

Continued antibiotic resistance indicates a need for new strategies to minimize antibiotic-resistant bacteria and make long-lasting improvement, according to a perspective piece in the *New England Journal of Medicine*.

The authors group these new strategies into the following five categories:

1. Preventing infection and resistance. One tactic in this category is using automated disinfectant in hospital rooms, according to the study.

2 Refilling antibiotic pipeline by aligning economic and regulatory approaches. Government or non-profit grants can help support antibiotic research.

3. Preserving available antibiotics, slowing resistance. For example, healthcare providers can publicly report antibiotic-use data for benchmarking and reimbursement, the authors wrote.

4. Developing microbe-attacking treatments with diminished potential to drive resistance. Immune-based therapies are one example of microbe-attacking treatments.

5. Developing treatments attacking host targets rather than microbial targets to avoid selective pressure driving resistance. For example, healthcare providers can employ direct moderation of host inflammation in response to infection. ■

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