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5 Facets of a True Patient Safety Culture

By Jaimie Oh

Healthcare organizations across the country have significantly ramped up the focus on patient safety and quality improvement, and for good reason. Under the healthcare reform law, healthcare providers' reimbursements will be linked to the quality of healthcare services, including patients' experiences, starting in 2013. A slew of efforts — federal demonstration projects, provider-payor

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5 Reasons Why Readmission Reductions Require Integrated Care

By Sabrina Rodak

Many hospitals are targeting readmissions as a way to improve quality and reduce costs. Beginning in October 2013, Medicare will reduce reimbursement for hospitals with frequent potentially preventable readmissions for heart attack, heart failure and pneumonia patients. By 2014, hospitals with high readmission rates could lose up to 3 percent of their regular Medicare reimbursements.

Tackling readmissions is a difficult task, however, because transitioning patients from the hospital to another care setting involves the coordination of multiple care providers, including specialists, primary care physicians, pharmacists and potentially home health providers. The traditional model of hospitals operating in silos is thus the an-

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What's Keeping CMOs Up at Night? 5 CMOs Share Their Biggest Challenges, Strategies for Success

By Lindsey Dunn

Health system and individual hospital chief medical officers face a number of new challenges that are markedly different from those of their predecessors. While quality improvement and patient safety are still paramount, efforts to integrate and coordinate care in preparation for value-based and capitated payments further expand the role of the CMO. *Becker's Hospital Review* asked several hospital and health system CMOs about their goals for their healthcare organizations, the obstacles they face and how they plan to deal with these challenges.

Steven Berkowitz, MD, Founder, SMB Health Consulting; Former CMO, St. David's Healthcare in Austin, Texas. "The overriding primary concern or challenge for all CMOs is all hospitals are dealing with unprecedented cost pressures, and we will see more pressure on cost reduction than we have ever seen in our careers. Given that pressure, how do we continue to improve our clinical outcomes and patient safety? That is the single biggest challenge of the medical officer today."

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collaborations and provider-level pilot projects, to name a few — are cropping up as the healthcare industry prepares for this shift in healthcare delivery.

Amid all these efforts, healthcare organizations must maintain a fundamental aspect of patient safety and quality improvement — patient safety culture. Matthew Lambert, MD, senior vice president at the healthcare consulting firm Kaufman Hall and vice chair of the board of directors at Sisters of Charity of Leavenworth Health System in Lenexa, Kan., and Alex Vandiver and Coleen Smith, RN, of The Joint Commission's Center for Transforming Healthcare, discuss the five aspects of maintaining a patient safety culture.

1. Patient safety culture starts at the top. It would be difficult to establish and maintain a patient safety culture if it did not start at the highest level of the healthcare organization, Dr. Lambert says. Governing boards, directors and executive leadership must promote a culture of safety and make their commitment evident to the rest of the organization.

"[Healthcare leadership] has to let everyone know that the well-being of patients and the quality of care they receive is the organization's goal and reason for being," Dr. Lambert says. "It should be the first thing everyone thinks about when they come to work and the last thing they think about before going home. It's a tone set by leadership, not something you talk about once in a while."

Visibility to staff. As the old adage goes, executive leadership also must "walk the talk" in order to foster a patient safety culture at their respective healthcare organizations. Dr. Lambert says board members and executives must move from the meeting rooms to patient care units and connect directly with physicians, nurses and patients. Increasing visibility shows both staff members and patients that the leadership's commitment to patient safety does not stop in the board room or the C-suite.

Visibility to other leadership. Dr. Lambert adds leadership must convey its commitment to one another at regular board or management meetings by making quality and patient safety the very first topic on the agenda. This emphasizes that patient safety is the most important issue for discussion.

At Sisters of Charity of Leavenworth, quality/safety committee meetings always begin with a patient care story. "These patient stories, which can be good or bad, bring quality and safety to the board in real human terms," he says. "A member of the executive team delivers that patient story, which can represent a failure or success by the organization to delivery safe care. Everybody loves it, and it certainly makes the discussion much richer. In addition, the board chair and the system's CEO attend every meeting."

2. Patient safety culture is driven by a vision. Healthcare leadership must create a vision that will drive the organization's patient safety culture. This requires executives and board members to conduct a gap analysis to understand where the organization exists in the spectrum of safety and where it wants to be, Dr. Lambert says.

"Part of that understanding includes both clinical metrics to evaluate performance, such as compliance with recognized standards of care and complications such as wound infections or unexpected deaths, as well as metrics to evaluate the patient experience," he says. "Once the leadership establishes where the organization stands in the universe of safety cultures, then they can envision how to move forward."

3. Patient safety culture involves everyone at every level. Once the gap analysis is completed, hospital leadership can take steps to promote and develop a patient safety culture. Dr. Lambert says it begins with communicating the gap analysis — where the organization is and where it should be — to every employee, physicians, and members of the board. Everyone must be involved in developing the action plans necessary to close the gap and improve the quality and safety for every patient. Action plans developed without the input and buy-in of staff members and physicians will most likely fail, Dr. Lambert says.

Mr. Vandiver, who acts as director of business excellence at The Joint Commission's Center for Transforming Healthcare, adds leadership must encourage staff members to speak up and foster a safe environment of accountability. "When we talk about safety culture, it's also about building comfort levels between different levels of staff so they can discuss how to improve quality and patient safety," he says. "Often, this requires breaking down some of the traditional internal structures both between multidisciplinary team members and between clinicians and non-clinicians to enable this improvement discussion." The first step towards establishing a true culture of safety is a sense that every voice is heard no matter what level they are in the organization.

3. Patient safety culture requires some evolution. Ms. Smith, who serves as sentinel event specialist at The Joint Commission's Center for Transforming Healthcare, says patient safety culture is not a one-size-fits-all solution. Healthcare organizations are complex structures, comprised of many different units with different needs, different staff members and different patients. Data from AHRQ's *Hospital Survey on Patient Safety Culture 2011 User Comparative Database Report* supports Ms. Smith's insight. For instance, results from the survey show nonteaching hospitals consistently rated patient safety culture composite items higher than teaching hospitals. Ultimately, this means safety cultures will change and evolve to fit the needs of unique healthcare enterprises.

For example, some hospital units may have a good team structure, where staff members are supportive and willing to stop each other when they don't exercise patient safety. Other units might have staff members who are more hesitant to speak up when they see a colleague has not complied with patient safety protocols. The change in safety culture requires courage since some of the changes will be counterintuitive to traditional processes and protocols, Ms. Smith says.

"It's important for organizations to look at safety culture not as a one-time fix or a few simple steps to improve quality. It's recognition that this is a journey, and there are many steps the organization must take to make it a success," Mr. Vandiver says.

4. Commitment to patient safety culture is consistent. One of the most common pitfalls that typically undermines the development of a patient safety culture is inconsistency in the leadership's commitment, Dr. Lambert says. That commitment may be broken once priorities become misaligned.

"A hospital board and executive leadership may say they are committed to patient safety, but they may cut funding for patient safety education programs at the first sign that the organization is in a difficult financial position," he says. "That kind of message clearly says to the rest of the organization that safety is not the first priority, and that can really disillusion employees."

Another common inconsistency in the message can be found in how leadership handles a medical error. It is absolutely critical that the leadership remembers that medical errors are almost always the result of

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systematic flaws rather than individual incompetence, Dr. Lambert says. When medical errors happen, the leadership must look at ways to improve systematic processes in order to prevent future adverse events from occurring — rather than punishing the individual that made the mistake. "These kinds of inconsistencies can cause staff members to be more jaded and less involved with patient safety efforts," he says.

Ms. Smith adds the healthcare industry is beginning to recognize the importance of effective and responsible responsiveness to adverse events. "Over the last 10 years, we were seeing the industry go from one end of the spectrum to the other — from a culture of punishment to one that lacked accountability," she says. "I think the healthcare industry is generally swinging back so the safety culture balances accountability and honest mistakes."

Federal data suggests there is still work to be done in this area. Results from AHRQ's *Hospital Survey on Patient Safety Culture 2011 User Comparative Database Report* show that less than half of respondents (44 percent) feel a non-punitive response to medical errors.

5. Patient safety culture ultimately transcends the leadership. Eventually, successful implementation of a patient safety culture should come full circle. Dr. Lambert says the best measure of whether an organization has achieved this is to see how well the organization's patient safety culture continues to thrive once there is a change in leadership.

"If I was a CEO of an organization and I planned to move on, the patient safety culture should stay the same. The culture should not depend on any individual or any group, it naturally becomes a part of the fabric of the organization," Dr. Lambert says. "When the leadership goes back to survey patients and employees, there should be a real shift in attitudes and perceptions on how care is delivered over time and a consistent focus on the patient at the center of every effort at improvement."

Mr. Vandiver adds that the success of a safety culture will also manifest itself in many ways. "Safety culture is a big term that is a component of many specific efforts to improve patient safety, including hand hygiene compliance, and efforts to reduce wrong-site surgery and surgical site infections," he says. "Beyond some of the core tactical barriers and problems that were identified by The Joint Commission's Center for Transforming Healthcare projects, safety culture was a contributing factor linked to some of the risks identified. Once the culture improved, that led to improved outcomes in these projects, but also helped enable patient safety beyond the scope of these projects." ■

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5 Reasons Why Readmission Reductions Require Integrated Care
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tithesis of an appropriate structure for successfully preventing readmissions. Hospitals instead need to integrate their services to ensure the patient will receive adequate care post-discharge.

"A readmissions [initiative] is a good place to start learning how to integrate hospitals, clinics, home health and other services in a more patient-centric way to coordinate care," says Alan Kaplan, MD, vice president and CMO of Des Moines-based Iowa Health System. "Focusing on readmissions requires we break down silos and focus on the continuum of care and not just what happens in the hospital."

Dr. Kaplan shares five reasons why reducing readmissions requires integrated care.

1. Primary care physicians. Physician integration with hospitals facilitates communication, such as notifying physicians when their patient has been admitted and providing the physicians with a discharge summary. This integration also helps ensure the patient is seen by the primary care physician shortly after discharge.

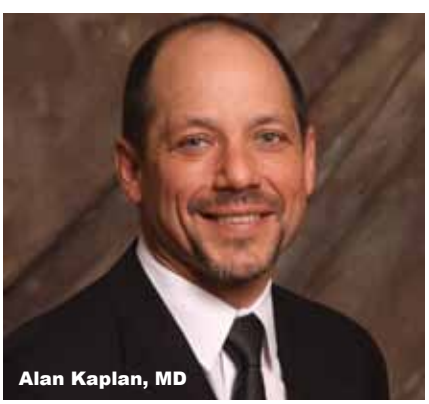
IHS, an integrated health system, has encouraged its employed physicians to implement best practices in their clinics to reduce readmissions. One of these best practices is seeing the patient within three to five days after discharge to confirm the patient is educated about his or her condition and that medication reconciliation has been performed. If the patient presented to the emergency department, the physician also discusses the reason for the patient's visit to try to prevent the need for another hospital stay.

2. Home health. IHS owns a home health agency in addition to hospitals and clinics, which allows the health system to more easily plan patients' care after leaving the hospital. In fact, a lack of a home health referral for patients may be one cause of readmissions, Dr. Kaplan says.

3. Stakeholders. Integrated hospitals and health systems can also more easily bring stakeholders together when coordinating a patient's post-discharge care. "People across the care continuum need to start working together in a way [they] have not worked together before," says Dr. Kaplan. Essential to working together is effective communication both between healthcare providers and between providers and patients. "There needs to be communication between hospitals, home health, clinics and skilled nursing facilities to make sure patients are well-educated about their condition."

Family members are also stakeholders in a patient's care. "It is extremely important that close family members are brought in on decision-making and understand the care plan," Dr. Kaplan says. Family members can help create a home environment that supports the patient's care, reinforce education and medication requirements and transport patients to appointments after discharge. Integrated healthcare organizations can more easily connect family members with the resources necessary to support the patient because of the variety of services the organization offers.

4. Culture. Integrated healthcare delivery also helps focus an organization's efforts on reducing readmissions through a unified culture. The different cultures and philosophies that exist between separate healthcare providers make it more difficult to coordinate care.


Alan Kaplan, MD

5. Reimbursement. In addition, integrated care can reduce readmissions more effectively because incentives and payment systems are aligned under one organization. "It's very difficult to coordinate all the providers involved [if] they all have different interests and different ways they're reimbursed," Dr. Kaplan says. In fact, he suggests that one of the causes of healthcare's current silo-based system is the different reimbursement systems for separate organizations. "It was driven [in part] by the payment system and the fact that most of us don't exist within an integrated delivery system. We have our own corporations, strategies and cultures, and so each business is separate and not necessarily coordinated. Sometimes it's very difficult to share information and collaborate under those conditions."

Dr. Kaplan anticipates the change from a fee-for-service to pay-for-performance model under healthcare reform will encourage more integrated care and thus facilitate system-wide initiatives such as reducing readmissions. "It will drive people to work together more collaboratively to improve care and eliminate waste." ■

What's Keeping CMOs Up at Night? 5 CMOs Share Their Biggest Challenges, Strategies for Success

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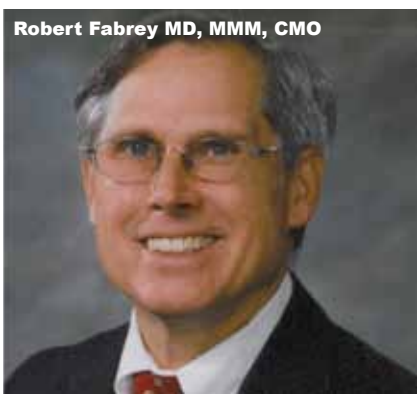
Steven Berkowitz, MD

Dr. Berkowitz believes — like many throughout the industry — these pressures will dramatically change "how we do business." While he expects this change to be a challenge for both CMOs and the overall healthcare delivery system, he is optimistic about this transformation. "It's not all doom and gloom," he says. "I believe with effective management on part of the CMO and the rest of the hospital team, we'll get to [a better model for healthcare delivery]."


Robert Fabrey MD, MMM, CMO

Robert Fabrey MD, MMM, CMO, San Juan Regional Medical Center in Farmington, N.M. Dr. Fabrey agrees that declining reimbursement is a top concern for physician leaders, as are physician and healthcare workforce issues and uncertainty surrounding funding for infrastructure.

Joel J. Reich, MD, MMM, FACEP, Senior Vice President for Medical Affairs and CMO, Eastern Connecticut Health Network, based in Manchester. "The biggest problem most of us are facing right now is not losing focus of day-to-day issues of quality, safety and customer service [while preparing for value-based care]. These are the keys to better outcomes, expense reduction and maximizing resource utilization regardless of payment system."


Joel J. Reich, MD, MMM, FACEP

Dr. Reich adds that strengthening the role of physicians in health system leadership will also be critical. "The role of physicians in health system leadership to help manage the direct business-clinical connection (e.g., pay-forperformance, pay-for-outcomes, accountable care, bundled payments, etc.) will require increasing interest by physicians to participate in leadership, leadership training and an interest by health systems to create truly meaningful roles," he says. "We realize that employment is not the answer in itself."

Instead, these physicians must play a role in building the infrastructure needed for accountable care and designing the processes (e.g., disease management processes) used to reduce variation and improve care. Additionally, physician leaders should play a role in helping to integrate the continuum of care through "connecting hospitals, physicians, home health care and extended care facilities through business, clinical and information technology relationships," says Dr. Reich. They will also play an instrumental role in determining when is the right time for the hospital or system to actually form or join an accountable care organization or other coordinated models. "Timing is everything. Moving either too slowly or too aggressively could result in significant quality of care issues and potential financial losses," he says.

Joseph Salipante, MD, FACP, Vice President for Medical Affairs and Medical Director, Unity Health System in Rochester, N.Y. "The biggest challenge will be to decrease the hospital length of stay, when appropriate, for hospitalized patients. Providing efficient care requires close collaboration and communication among doctors, nurses, other caregivers, patients, their families and sites of care outside the hospital. It is often a challenge to fully coordinate the care a patient requires in such a complex process. Unity Health System is striving to continuously improve the effective coordination of patient care."


Joseph Salipante, MD, FACP

In response to this challenge, Unity is focusing its efforts on teaching patients and families about their responsibilities in managing illness and developing processes of care that provide established standards of care and reduce variability. "The goal is the development of an effective team with the patient being at the center of our efforts to provide optimal care and outcomes," says Dr. Salipante. Dr. Salipante recommends other CMOs working to improve quality of care abide by the following best practices: Set clear goals for each initiative, obtain buy-in and commitment to the goals; hold physicians and others accountable for the results of the initiative; develop meaningful measures for the results and share them often; and celebrate success and critically review the causes for less than optimal results of any initiative.


Linda Efferen, MD

Linda Efferen, MD, CMO of South Nassau Communities Hospital in Oceanside, N.Y. Dr. Efferen explains many challenges currently facing South Nassau and healthcare in general are caused by uncertainties surrounding healthcare reform. "We all know we need to be more efficient, which speaks to the need to look outside the proverbial box in terms of our prior way of taking care of patients," she says. "We need to be moving toward a different model of care, but not knowing where that's going or how we're going to be reimbursed [creates significant challenges]." ■

Capella CMO Dr. Erik Swensson: Physicians Leading a Culture of Safety

By Sabrina Rodak

As physicians and hospitals continue to align, whether through employment, co-management or other partnership models, healthcare leaders are realizing the importance of involving physicians in major initiatives, such as those to meet meaningful use, optimize efficiencies and improve quality. In addition, as collaborative care models such as accountable care organizations and patient-centered medical homes grow, physicians will gain a more central role in healthcare delivery. For these reasons and others, Erik Swensson, MD, CMO of Franklin, Tenn.-based Capella Healthcare, believes physicians need to be leaders in patient safety and quality.

Leaders in action, if not in title

All physicians, whether in formal leadership roles or not, are leaders, according to Dr. Swensson. "Although healthcare is a team, there has to be a coach for the team, and the coach is normally the person with the most experience, training and expertise — and that normally is the physician." The amount of training required of physicians makes them leaders almost by default, he says.

However, physicians can be successful leaders only if they build on their clinical training and knowledge by learning how to teach by example and mentor others. "I don't expect every doctor to want to be chief of staff or play on the national scene, but I do expect them to be safety-conscious and educated in what a culture of safety is," Dr. Swensson says. Unfortunately, medical schools traditionally do not train physicians in leadership skills, which means hospitals have to encourage physicians and invest in them as leaders. "As physicians, we're taught to make the correct diagnosis, to implement the correct treatment — whether medical or surgical — to be compassionate and to care about people. But no one really talked about the process of safety or the culture of safety," he says.

Building a culture of safety

While physician education is starting to shift as the healthcare industry focuses more on quality and patient safety, there are already a couple generations of physicians in practice who were trained before a culture of safety was even discussed, according to Dr. Swensson. Building a culture of safety may thus be new and more difficult for some physicians than others.

A culture of safety depends on a belief that everyone has a role in keeping the patient safe, he says. One of the key factors in creating this culture is developing positive, inclusive attitudes toward everyone in the environment, from the custodial staff to the CEO. Just as a hospital CEO's decisions on the organization's policy can affect patient safety, a physician's clinical work and a custodial staff member's cleaning practices can affect infection rates.

While exhibiting this attitude may seem easy for people trained to care for others, it can become a challenge in times of high stress, which hospitals and health systems are no stranger to. The relationship between physicians and nurses can be a particular challenge because they work together so often and tensions may build. Keeping communication lines open for nurses and other staff is critical, especially in a high-stress situation, to ensure safety and quality. Even one instance of failed communication, whether due to misunderstanding, fear or anger, can jeopardize the relationship for all future interactions. If a physician reacts negatively to a nurse's comment or question regarding safety or quality, the nurse may be discouraged from ever speaking up again, which puts patients — and clinicians — in danger. "If the team is afraid to speak up, you can't have a culture of safety," Dr. Swensson says.

As leaders, physicians have a responsibility to respond appropriately to questions concerning safety and quality. "It's a tough business; we're dealing with pain and suffering. If you're going to take that responsibility, you have to be strong enough to say, 'Yeah, I am tired. Yeah, I don't want to hear that I missed something. But I have to look at the big picture, be objective and say to the nurse thank you for reminding me, thank you for stopping me from doing something [incorrectly,]'" he says.

Furthermore, responding to questions on safety and quality should not be one-liners — only a 'thank you' — it should be a discussion. "Physicians should be educators. If you have a student, nurse or physician assistant ask a question, you can't be mad at [him or her]. You have to respond appropriately and answer it," Dr. Swensson says. When he practiced as a surgeon, he says his nurses were not afraid to talk to him or question what he was doing. "And sometimes they would be wrong. And if they were wrong, I would educate them on why I was doing what I was doing."

Solving small problems first to solve bigger ones later

Physicians' relationships with the hospital C-suite is also a critical element of a culture of safety. Physicians and hospital executive leaders can develop a strong relationship by regularly working together in a non-threatening way. "As a corporation, we feel that doctors and the C-suite should have a type of regular interaction that is not crisis-driven," Dr. Swensson says. "If the only time you talk is when you're in crisis, it's a very difficult interaction. But, if you talk about small problems, and what [each other's] philosophy is, then when you hit crisis time, you're much more aligned to take care of the problem."

For example, at each of Capella Healthcare's hospitals, a team of six to 12 physician leaders meet with the CEO quarterly to discuss various issues. Capella encourages the group to meet outside the hospital, such as in a restaurant, to talk about the medical community — what the problems are and how to solve them — in a comfortable environment. In addition, members of the hospital C-suite do rounding with physicians regularly, and the CEO has an open-door policy. "When that connection is made, you already know the person, and you already have some successes — you know you can solve problems, as opposed to walking in for the first time, both sides feeling like they have to protect their turf," Dr. Swensson says. A positive physician-C-suite relationship can ensure that hospital leadership can confront patient safety and quality issues head-on in a collaborative fashion. ■

UC Davis CMO Dr. Allan Siefkin: 7 Ways Hospitals Can Elevate Their Quality Efforts

By Sabrina Rodak

Healthcare reform's emphasis on patient safety and quality has motivated many hospitals and health systems to create a culture that supports safety and quality. Embedding a patient safety and quality focus in a hospital's culture is essential to improve in these areas because it illustrates to physicians and staff that quality and safety initiatives are not one-time events, but part of an overall, long-term commitment to quality and safety. Allan D. Siefkin, MD, CMO of University of California Davis Medical Center in Sacramento, explains how strong leadership and continuous improvement can help create a robust culture of patient safety and quality.

Accepting responsibility

A culture of safety and quality requires everyone in the organization to accept that improving safety is possible. "You have to get beyond denial, saying our patients are different or we are referred all the socioeconomically challenged people," Dr. Siefkin says. Debunking the myth that clinicians have no control over adverse events is crucial to fostering an environment that encourages physicians' and employees' engagement in safety and quality initiatives.

Leaders must prioritize patient safety and quality

A culture of safe and quality care needs to start from the top and spread across the entire organization. At UC Davis Medical Center, the CEO holds monthly leadership meetings that include reports on every patient safety and quality initiative. About 50 percent of the agenda at these meetings is related to safety and quality, according to Dr. Siefkin. By prioritizing safety and quality in the hospital, executives demonstrate to physicians and employees the importance of these issues to the entire organization.

Leaders can also show their commitment to safety and quality by developing formal safety and quality programs. The University of California launched its Center for Health Quality and Innovation in October 2010. The center provides grants to UC medical centers for quality initiatives and other innovative projects. For example, CHQI funded an effort to standardize the assessment of deep vein thrombosis across all UC hospitals.

Educate the next generation

Focusing on safety and quality as key factors in a hospital's success is a relatively new trend. Dr. Siefkin suggests academic medical centers may face a greater challenge than non-academic institutions in balancing safety and quality targets with other goals because of the centers' multiple missions, including education. Integrating safety and quality with academic medical centers' educational role can help hospitals shift efforts to more directly address safety and quality.

In 2011, UC Davis Health System launched the Integrating Quality Symposium: Linking Clinical and Educational Excellence, in which residents present papers and posters on safety and quality projects they're working on. UC Davis School of Medicine and the Betty Irene Moore School of Nursing are also looking into ways to include process improvement in the curriculum.

Be transparent

A culture of safety and quality requires leaders to be transparent about safety and quality initiatives — whether they are successful or not. Communicating successes and failures to the whole organization demonstrates the importance of these initiatives to the hospital or health system. UC Davis created an intranet site that shows the hospital's performance on different safety and quality metrics, such as mortality rates, complication rates and hospital-associated infection rates. All employees and clinicians can access the site.

Measure and track performance

Continually measuring and tracking safety and quality metrics gives the hospital clear, quantitative goals and motivates leaders and staff to always strive for improvement. Setting goals in safety and quality based on benchmarks helps create a culture of safety and quality because everyone in the organization is expected to do their part to meet these goals. Continuing to measure performance also indicates the hospital's long-term investment in safety and quality.

About five years ago, the CMOs and CNOs of all five UC medical centers met to discuss quality and decided to create a system-wide

dashboard of quality indicators. This dashboard allows the hospitals to compare their results to each other and track improvements. Results on the dashboard motivated UC Davis to target central line-associated bloodstream infections, as its performance in this area was ranked "worse than average," according to Dr. Siefkin. UC Davis and the other UC hospitals implemented best practices to lower the rate of CLABSIs and saved almost 100 lives and between $14 million and $15 million in direct costs across all five hospitals, Dr. Siefkin says.

Engage staff in improvement efforts

Engaging clinicians and staff in safety and quality initiatives is also crucial to building a culture that promotes patient safety and quality care. Forming work groups to address specific problems creates accountability and gives front-line workers an opportunity to apply their direct experience to safety and quality problems. UC Davis created a congestive heart failure readmission reduction team to prevent patients with congestive heart failure from needing to be readmitted. The group has reduced readmissions for this patient population 20 percent within eight months.

Promoting collaboration between clinicians and staff also contributes to a culture of safety and quality. UC Davis supported clinician collaboration in a project to reduce ventilator-associated pneumonia. The hospital involved nurse specialists as change agents to help teach physicians standard protocols, such as daily sedation holidays, in which sedative infusion is stopped until the patient wakes, and is then restarted.

Never give up

While continuous improvement is always the goal, there will inevitably be some initiatives that do not meet the target. Instead of giving up and viewing the initiative as a failure, hospitals should learn from the experience and try different tactics until they reach the goal. Dr. Siefkin suggests analyzing each separate event for its root cause and acting to prevent the event from recurring. "Once you get to a certain point, you don't get discouraged," Dr. Siefkin says. "You figure out another way to do it," he says. Hospitals can also keep improvement teams motivated when an initiative does not succeed by creating some competition. For instance, UC Davis posted providers' success with reducing pressure ulcers in each unit to encourage everyone to improve. ■

Improving Cost, Quality Through Provider-Sponsored CO-OPs

By William C. Mohlenbrock, MD, FACS, Chief Medical Officer, Verras Ltd.

Healthcare is one of the largest industries in our country, and interestingly, is one of the only, along with perhaps education, that lacks transparent and comprehensible metrics to objectively measure the quality of its products and services. This fundamental deficiency frustrates American consumers who are accustomed to purchasing goods and services on the basis of value. The inability of healthcare providers to satisfactorily articulate their quality outcomes has resulted in price becoming the default purchasing metric for health insurance companies and HMOs. This is troublesome as price has no real meaning without a measure of quality, leaving employers and patients with little or no idea what value they are receiving for their healthcare dollars.

Physicians' primary incentive is to deliver the highest quality patient care. Costs are secondary considerations, in spite of the fact physicians direct about 80 percent of all inpatient dollars and 100 percent of all dollars in their offices. Physicians are not indifferent to costs, but the disincentives for them to be cost efficient are numerous and significant. Patients want them to "spare no expense," and Medicare and most insurance companies pay physicians on a modified fee-for-service basis that maximizes their revenues when they order and interpret more tests and treatments. Paradoxically, physicians' greatest disincentives arise when they actually conserve the hospital or third party's resources. The resulting financial rewards only accrue to either the insurance company or to the hospital, never to offset the physicians' malpractice risk of not having ordered a test or treatment that he or she believed to be clinically indicated.

Unless physicians practice in an HMO or staff model clinic setting, there are few, if any, financial inducements for cost containment. In fact, these conflicting incentives have been partially responsible for decades of spiraling healthcare costs with the only financial winners being insurance companies and HMOs. Rewarding third-party payors for anything other than administering payments is a misallocation of precious resources and a major contributor to our unsustainable healthcare inflation rates. America is now at a crossroads. If we are unable to deliver consistent quality outcomes and gain control of healthcare costs, our entire financial structure is on a downward slope to failure.

However, a few recent developments now make quality and cost controls achievable. Most notably, federal legislation facilitates the formation of Consumer Operated and Oriented Plans for health insurance. These can be sponsored by providers and can serve as a means to align hospitals' and physicians' incentives as well as reimburse them for producing high-quality, cost-efficient care. While the Patient Protection and Affordable Care Act also creates several programs within CMS to achieve the same quality and efficiency goals, CO-OPs are noteworthy because they deal with private health insurance. Success under these models requires technologies that facilitate physician-directed best practice improvements in clinical and financial outcomes. Luckily, these tools are available and accessible to hospitals and medical staffs that are motivated to use them. Further, the output of these technologies furnishes physicians, hospitals and employers with transparent and easily understood performance measures of hospitals' and physicians' clinical and financial outcomes.

Employers who insure their employees through a regional CO-OP will experience the benefits of value-based healthcare purchasing with lower premiums and greater patient satisfaction. Participating providers will benefit by self-determined quality controls and sharing of financial savings — based on objective and transparent measures of quality and efficiency.

CO-OP legislation

Decades of competing healthcare factions, disincentives to improvements, third party intrusions and providers' inability to deliver value have created a bizarre triad of: excessive profits for third-party payors who don't dispense care; insufficient funding for dedicated providers who deliver care and diminishing services for patients who need the care. Chaos in the system and distrust among all parties has ensued making the promise of value-base healthcare purchasing an elusive goal for patients as well as public and private employers — until now.

Over the years, Medicare inflation has been consistently 3 percent higher than the consumer price index. The Congressional Budget Office stated in June 2010, "Slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for federal fiscal policy." This imperative to successfully control public outlays resulted in part, with the passage of the PPACA. Section 1322 of the law defines CO-OPs as non-profit insurance companies. Prior to passage of PPACA, a bipartisan group of senators were said to have created this concept as a means of facilitating a competitive model to traditional health insurance companies.

Hospitals and physicians are consumers and can therefore integrate themselves and form a "provider-sponsored CO-OP." The provider version of CO-OPs is probably the most likely to succeed because hospitals and physicians have a vested interest in, and are the actual means of accomplishing the stated goals of producing high-quality care and containing costs. CO-OPs will facilitate these outcomes by

aligning physicians' and hospitals' incentives to improve quality outcomes and share savings — when their utilization of medical resources is appropriate and efficient.

The federal government initially allocated $3.8 billion to assure the success of CO-OPs by providing both start-up funding and reserves that all insurance companies must maintain. Organizations wishing to become a CO-OP must submit appropriate requests for funding to HHS along with their proposed board structures and business plans. If selected, the funding is made available to the CO-OP's board as very favorable loans. The organizational structure is a 501(c)29 not-for-profit insurance company that excludes traditional insurance companies from either becoming a CO-OP or interfering with its formation.

When combined with best practice improvement technologies and transparent clinical-quality outcomes, the CO-OP model has every opportunity to rapidly accomplish verifiable quality improvements and cost containment. It will accomplish these goals by aligning the incentives of all stakeholders, facilitating the means for hospitals and physicians to improve clinical and operational quality and create a value-based healthcare delivery system with which employers and patients will eagerly contract to receive the benefits of lower healthcare premiums and objectively defined, high-quality care.

Federal (Medicare) and state (Medicaid) purchasers will experience the same quality improvements and financial benefits for their beneficiaries as CO-OP patients receive when physicians are incentivized to "bend the cost curve."

Creating value with quality-improvement

A key goal of hospitals and other providers engaging in the CO-OP model must be to reduce variation in clinical and organizational processes. The following three steps further explain how this can be achieved.

Implementing physician-directed best practices. When clinicians and hospital personnel create reductions in outcomes variations and document appropriate utilization of resources through physician-directed best practices, the hospital-physician enterprise can be assured there will be net savings for sharing. Hospitals' all-payor medical records data are the most readily available and reliable basis for physician-directed best practice assessments. These patient-level data must be risk-adjusted and formatted for ease of physicians' use to quantify the hospital's and clinical services' clinical outcomes. Financial (resource consumption) data must also be aggregated in a similar manner to demonstrate the wide variations that exist in physicians' care processes and outcomes. Charges are an excellent surrogate for the number of resources consumed since each hospital's chargemaster is the same for all resources and physicians. If a hospital's costs are available, they can and should be used in place of charges. Length of stay should also be displayed with charges to give a graphic display of the variations that exist within relatively homogeneous patient cohorts.

Evaluating physician performance. Drill-down techniques using patient-level data can be deployed to reveal each physician's own best-demonstrated performance and then contrasted to his/her patients with inefficient outcomes. This can only be accomplished if the data is of sufficient granularity that the physicians can identify which of their specific diagnostic, treatment and choices of consultants demonstrated greater and lesser efficiencies. The differences in these patient cohorts define physicians' practice variations.

Comparing physicians' performances using their own variations and outcomes with those of hospital peers is a powerful way to rapidly effect practice pattern changes. These best practices are most effectively shared during one-on-one educational and non-threatening educational sessions. The vast majority of clinicians embrace these methods because physicians desire to continuously improve, but they need reliable clinical information with which to work.

Evaluating hospital performance. Hospital personnel must also engage in similar activities. Simultaneous with the physician-level implementation, the drill-down techniques should target those patients in which hospital-induced inefficiencies have prevented physicians from reducing clinical variations or moving the patients through the hospital in the most expeditious fashion. One of many hospital-induced inefficiencies is the lack of certain diagnostic equipment or discharge planning on weekends. In my experience, half of a hospital's inefficiencies are directly caused by hospital impediments as opposed to being physician-induced.

Measuring quality improvement

Physicians and hospital personnel are often willing to adjust their own practices to fit best practices if data can be provided to support doing so will bring about improvements. However, some health systems fall into the trap of overwhelming them with data, which they are unable to interpret and act upon. In order to show quality improvement data in a straight-forward, easy-to-comprehend manner, Verras recently developed the Index of Quality Improvement. The IQI consists of six industry-standard measures, which hospitals and physicians have historically used to objectively measure quality and cost efficiency outcomes. The quality metrics must be trended over at least three years to accurately reflect providers' abilities to improve their outcomes.

The IQI affords providers a comprehensible means of marketing the CO-OP to local employers and self-pay patients. Moreover, the IQI metrics are excellent for comparing the efficiencies of competing HMO or other enterprises, using publically available data.

The six IQI metrics are as follows:

1. National Hospital Quality Measures and The Joint Commission metrics, including patient satisfaction
2. Patient readmission rates – 30-day, risk-adjusted
3. Mortality rates – risk-adjusted, including 30-day rates
4. Morbidity rates – risk-adjusted complications
5. Reductions in variation (RIV) – most resource intense 5 DRGs per the top 5 MDCs
6. Financial – resource consumption as measured by inflation of charges

Dividing savings among CO-OP providers

One of the biggest challenge facing providers who participate in any of the bundled-payment models, ACOs or in a CO-OP will be determining how to divvy up any savings achieved. The percentages and categories for hospital distribution of net savings are determined by the CO-OP board (generally consisting of employers, hospitals and physicians), and then the board or hospitals determine the physicians' percentages.

Take for example a hypothetical eight hospital CO-OP that achieved a $20 million year-end net savings. The savings would be divided between first the employers and patients ($10 million in premium reduc-

tions) and the eight hospitals according to the CO-OP board's decision. In this example, a quality improvement score, such as the IQI, facilitates the dividing of the $10 million provider portion among the eight hospitals based on clinical and financial outcomes.

Verras recommends using three categories to determine hospital reimbursements: 1) high initial quality scores to reward past performance, 2) improvement in quality and cost efficiency performance during the year and 3) equal-share percentage for participation in the CO-OP. These three categories can be weighed according to the board's determination.

Next, distribution to physicians must be determined. The distribution of dollars between the hospital and entire medical staff is generally based on a sliding scale from 50 to 80 percent. The greater the objective quality and efficiency outcomes produced by the physicians over the year, the greater the percentage of dollars that are allocated to the participating medical staff members. It should be noted that the hospital would experience significant Medicare and Medicaid savings that accrue as the medical staff increases their clinical efficiencies. The hospital's Medicare and Medicaid net gains are not shared with the independent physicians due to Stark regulations, unless the hospital participates in a CMS-regulated shared savings program. These restrictions do not apply to the commercial patients covered under the CO-OP insurance plan.

Finally, the hospital's medical staff members should divide their share of the net savings according to each clinical services' improvements in four recommended measurement areas: 1) resource consumption, 2) reductions in variation, 3) mortality and 4) morbidity. This will ensure that those clinical services that achieve the most improved quality and efficiency outcomes will receive the greater reimbursements.

Conclusion

The provider-sponsored CO-OP model is arguably the most efficient, effective and predictable, public-private healthcare delivery system ever devised because it aligns the incentives of physicians and hospitals as well as financially rewards them for quality outcomes. Regional hospitals and medical staffs can create a CO-OP and utilize the hospitals' readily available data to implement physician-directed best practices that will continuously improve their clinical and financial outcomes. Sharing the net savings between employers, patients, hospitals and physicians will bring value to an entire region where the CO-OP can successfully compete with traditional insurance companies and HMOs.

Employers will readily embrace this model because they devoutly desire to purchase high-quality, cost-efficient care for their employees. This will align with the incentives of their local physicians and hospitals that are motivated to produce objectively defined value for their patients. Through the CO-OP, employees and self-pay patients can be directed to the highest-quality, most cost-efficient providers thereby creating a rational medical market that rewards providers who demonstrate value.

The timing is right for significant change, and the provider-sponsored CO-OP model is the ideal strategy. It will fulfill the national cost containment imperative by transitioning our inefficient price-based medical sector to an effective and efficient, value-based healthcare delivery system — one region at a time. ■

Hospital and Health System CMOs on the Move

SSM Health Care, based in St. Louis, named **Gaurov Dayal, MD,** as the first senior vice president of physician innovation and integration and CMO.

Fitzgibbon Hospital in Marshall, Mo., announced **Darin Haug, DO,** as CMO.

Susan Melvin, DO, was named CMO of Long Beach (Calif.) Memorial Medical Center.

Northwestern Memorial HealthCare in Chicago named **Stephen Ondra, MD**, as CMO of Northwestern Memorial Hospital.

St. Vincent's Medical Center in Bridgeport, Conn., named **Lawrence Schek, MD,** senior vice president and CMO.

Howard Scott, MD, was named CMO of Methodist South Hospital in Memphis, Tenn.

Joseph Segeleon, MD, was appointed CMO of Sanford Children's Hospital in Sioux Falls, S.D.

Baptist Hospital in Nashville, Tenn., named **Geoffrey Smallwood, MD,** as CMO.

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