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BECKER'S
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10 Proven Ways to Reduce Hospital Readmissions

By Jaimie Oh

The reasons hospital and health system leaders should be concerned with driving down preventable readmissions are clear. Under healthcare reform, healthcare providers with high levels of preventable readmissions face the potential of losing a portion of their federal payments. The Hospital Readmissions Reduction Program, which is part of CMS' Inpatient Prospective Payment System, will reduce Medicare reimbursements to hospitals with high levels of preventable 30-day readmissions

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Evidence-Based Medicine: The Present and Future of Hospital Care

By Bob Herman

Recently, health insurer WellPoint partnered with IBM's Watson technology in an effort to help physicians diagnose and design treatment plans based on large amounts of data and evidence. Watson is most commonly known for appearing on "Jeopardy!" and taking down two former champions with its data-crunching abilities. In many regards, it is considered to be the poster "bot" for decision-making based on evidence and technology, which is becoming the new standard in healthcare. The Institute of Medicine's Roundtable on Value & Science-Driven Health Care predicts that "by the year 2020, 90 percent of clinical decisions will

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Linkage Between Readmissions and Quality Complex

By Jaimie Oh

A recent Trendwatch report, published by the American Hospital Association, examines the linkage between hospital readmission and quality, calling into question whether hospital readmissions is an appropriate measure of quality.

Under the healthcare reform law, the Hospital Readmissions Reduction Program will begin penalizing hospitals for higher-than-expected rates of hospital readmissions in fiscal year 2013.

The AHA report outlines four different types of hospital readmissions:

- A planned readmission related to the initial admission.
- A planned readmission unrelated to the initial admission.
- An unplanned readmission unrelated to the initial admission.
- An unplanned readmission related to the initial admission.

AHA draws attention to and expresses concern over the last category of unplanned readmissions related to the initial admission, stating "[hospitals] cannot influence the occurrence of unplanned, unrelated readmissions because they are not predictable or preventable."

AHA goes on to argue hospitals should not be penalized for planned readmissions if a patient's return visit to the hospital is critical to his or her treatment plan. ■

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FEATURES

Hospital and Health System Chief Medical Officers on the Move

Tim Appenheimer, MD, was promoted to vice president and CMO of Katherine Shaw Bethea Hospital in Dixon, Ill.

Dan Bailey, MD, was named CMO and vice president of medical affairs at Upper Valley Medical Center in Troy, Ohio.

Covina, Calif.-based Citrus Valley Health Partners named **Paveljit Bindra**, MD, CMO and chief medical information officer.

James F. Blute, III, MD, joined Nazareth Hospital in Philadelphia as associate CMO. Dr. Blute most recently served as CMO at Auburn (N.Y.) Memorial Hospital.

Theresa Brennan, MD, was named CMO of UI Health Care in Iowa City.

Robert J. Caldas, DO, was named CMO and senior vice president of Southcoast Hospitals Group, part of Southcoast Health System based in New Bedford, Mass.

Ravi Chari, MD, CMO of TriStar Health System in Brentwood, Tenn., stepped down from his post to serve as president of clinical excellence at HCA, which operates TriStar.

Julie Coffman Barnes, MD, was named CMO of Redmond Regional Medical Center in Rome, Ga.

Gregory Cooper, DPM, CMO of Mercy Medical Group in Sacramento, Calif., was named to the new position of CEO of the medical group, which is a service of Catholic Healthcare West.

Raymond L. Cox, MD, was named CMO of Providence Hospital in Washington, D.C. In addition to CMO, Dr. Cox was also tapped to serve the hospital as senior vice president of medical affairs.

Michael Cuffe, MD, vice president for ambulatory services and CMO of Duke University Health System, stepped down from his post on Oct. 26 to serve as president and CEO of Physician Services for HCA.

Laurence Eason, MD, was appointed CMO for the Providence Southern California Region, which includes five medical centers.

Piedmont Newnan (Ga.) Hospital named **Jeffrey R. Folk**, MD, vice president of medical affairs and CMO.

Stamford (Conn.) Hospital announced that **Sharon Kiely**, MD, was promoted to senior vice president of medical affairs and CMO.

Michael Murphy, MD, joined the executive leadership team at Sharp Grossmont Hospital in La Mesa, Calif., as CMO.

Stephen Nesbit, DO, was recruited to serve as CMO for Via Christi Hospitals Wichita (Kan.).

Loretta Ortiz y Pino, MD, was appointed CMO of Holy Cross Hospital in Taos, N.M.

David Pizzuto, MD, was named vice president of medical affairs and CMO of Waterbury (Conn.) Hospital.

Sebastian Rueckert, MD, was appointed CMO of Christian Hospital, a BJC HealthCare facility in St. Louis.

John Schlegelmilch, MD, retired from his position as CMO and president of Cheshire Medical Center/Dartmouth Hitchcock Keene, both located in Keene, N.H., on Oct. 15.

Kevin Tabb, MD, CMO at Palo Alto, Calif.-based Stanford Hospital & Clinics, became president and CEO of Beth Israel Deaconess Medical Center in Boston on Oct. 17.

The board of directors at Scotland County Hospital in Memphis, Mo., named **Randy Tobler**, MD, CMO of the hospital. Dr. Tobler has been on the hospital's medical staff since 2006.

Lehigh Valley Health Network in Allentown, Pa., named **Thomas Whalen**, MD, CMO.

Andy Whittemore, MD, CMO of Brigham and Women's Hospital in Boston, stepped down from his post. Dr. Whittemore served as CMO of Brigham and Women's since Jan. 1999 and was on the hospital's medical staff since 1976.

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Bill Mohlenbrock, MD, FACS
CMO, *Verras*

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10 Proven Ways to Reduce Hospital Readmissions (continued from page 1)

for three high-volume conditions: acute myocardial infarction, heart failure and pneumonia. Additionally, CMS' proposed Hospital Value-Based Purchasing Program includes measures for readmissions which will further penalize hospitals for high rates of preventable readmissions. Both programs take effect fiscal year 2013.

In addition to the high costs associated with preventable readmissions, preventable readmissions rates are increasingly being used as a quality indicator subject to scrutiny by commercial payors and consumers alike, which can affect your hospital's bottom line. Here are 10 proven ways to reduce preventable hospital readmissions, based on a combination of research and successful hospital initiatives.

1. Understand which patient populations are at greatest risk of readmissions. It is critical hospitals identify which patient populations are at increased risk of hospital readmissions to target specific patients. Research from the Healthcare Cost and Utilization Project suggests, for instance, that Medicaid patients and uninsured patients are at increased risk of preventable hospital readmissions, compared to privately insured patients. Specifically, HCUP's research showed maternal readmission rates were approximately 50 percent higher for uninsured and Medicaid patients than for privately insured patients.

What's more, among non-maternal adults (aged 45-64), Medicaid patients were readmitted to hospitals approximately 60 percent more often than uninsured patients. Similarly, they were readmitted to hospitals twice as often as privately insured patients.

2. Target patients with limited English proficiency. Healthcare experts agree patients with limited English proficiency are at increased risk of readmission. In fact, The Joint Commission recently established new requirements for hospitals delivering care to limited English proficiency patients. These regulations require proof of interpreter training and fluency competence for interpreters in spoken languages, as well as American Sign Language for deaf and hard of hearing patients. The standards are already in place as of this year but do not impact accreditation during the initial year-long pilot phase.

3. Participate in incentive programs with payors. Hospital and health systems across the country have been enrolling or partnering in incentive programs with payors designed to incentivize providers to effectively drive down unnecessary hospital admissions. Abington (Pa.) Health, for instance, and other Pennsylvania healthcare providers agreed in July to partner with Philadelphia-based Independence Blue Cross in a hospital-physician incentive program. The pay-for-performance model, aligned with federal accountable care guidelines, is designed to incentivize hospitals and physicians to collaborate in efforts to reduce hospital-acquired infections and readmissions and follow evidence-based guidelines for surgical care and the treatment of heart attacks, heart failure and pneumonia.

Similarly, the Maryland Health Services Cost Review Commission launched a voluntary program in March that caps payments for inpatient care over three years. Maryland hospitals could realize substantial savings if they reduced readmissions and lose money if readmissions rose. To meet the goal, participating hospitals would work with physicians and other providers in the community to ensure that patients receive the necessary care, preferably in lower-cost settings.

4. Join a readmission prevention-focused collaborative. Although they do not involve financial incentives, collaboratives can provide a way for health systems and hospitals to team together and share best practices and strategies for preventing hospital readmissions. The New Jersey Hospital Association, for instance, launched a year-long collaborative last June involving 50 hospitals, nursing homes and home health agencies to reduce hospital readmissions for heart failure. The goals of the collaborative included understanding why patients are readmitted; identifying best practices to reduce the rate; developing resources to improve care for heart failure patients and creating resources for patients to better manager their condition.

5. Ensure patients schedule a seven-day follow-up. Medical studies have suggested that patients who followed up with their physician within seven days of discharge were less likely to be readmitted to the hospital. CMS launched a pilot program from 2008-2010 in which hospital participants aimed to lower hospital readmissions within 30 days of discharge by 2 percent. Valley Baptist Medical Centers in Brownsville, Texas, and Harlingen, Texas, surpassed that goal, achieving 2.8 percent and 4.2 percent reductions in readmissions, respectively, by working with physicians to ensure patients were being scheduled for follow-up visits within seven days.

6. Implement a robust home healthcare program. Post-discharge care can also be a powerful mechanism for preventing readmissions. Research conducted by Avalere Health showed home healthcare, such as medical social services or home health aides, can be effective. According to Avalere's study, home healthcare for chronically ill patients resulted in an estimated 20,426 fewer hospital readmissions than chronically ill patients receiving other post-acute services, such as long-term acute-care hospital services.

7. Ensure smooth transitional care. In addition to home healthcare, transitional care has also been shown to reduce hospital readmissions. Transitional care could feature a transitional care team or professional who facilitates the coordination and continuity of care for patients as they change providers post-discharge. One study conducted at Baylor Medical Center at Garland (Texas) found a nurse-led transitional program reduced adjusted 30-day readmission rates by 48 percent.

Another study, published in the *Archives of Internal Medicine*, compared 30-day readmission rates between a control group and fee-for-service Medicare patients who received transitional care coaching. Results showed the group that received transitional coaching experienced a 12.8 percent 30-day readmission rate, compared to the group who did not receive coaching and experienced a 20 percent 30-day readmission rate.

Also, the nurse's role in transitional care should not be overlooked. Researchers conducted a systematic review of literature and analyzed 21 randomized clinical trials of transitional care interventions involving chronically ill adults. They discovered nine common interventions that helped drastically lower readmissions 30 days post-discharge, many of which included some variation of nurse involvement. Hospitals should position nurses in leadership roles, such as clinical managers or in-person home visitors for discharged patients.

8. Clearly communicate post-discharge instructions. Patient communication and education is a critical component of readmission prevention. At UCSF Medical Center, a team of multidisciplinary heart failure experts monitored heart failure patients after discharge. These experts target preventable readmissions by educating patients about their disease and utilizing the "Teach Back" method. This method requires the patient to repeat the information they have been taught to ensure full understanding. UCSF Medical Center's multidisciplinary-expert approach helped reduce 30-day and 90-day readmissions for heart failure patients 65 and older by 30 percent.

9. Install telemonitoring technology in the homes of chronically ill patients. Hospitals can also prevent unnecessary hospital readmissions by utilizing telemonitoring technology. A Horizon Blue Cross Blue Shield pilot program in New Jersey is closely monitoring congestive heart failure patients in their own homes in an effort to drive down hospital readmissions. Patients participating in the pilot program are equipped with a small transmitter that sends readings to Horizon BCBS. Anytime the transmitter senses a risk, such as weight gain, a Horizon BCBS medical professional is alerted to check on the patient without requiring an expensive hospital visit.

10. Effectively staff nurses during patient care. Another study showed effective and proper nurse staffing while the patients are still in the hospital can decrease preventable readmissions. A study published in *Health Services Research* examined data on nearly 1,900 patients at four hospitals from Jan.-July 2008. Notably, the researchers found higher RN overtime staffing increased readmissions as well as ED visits. Meanwhile, higher non-overtime RN staffing was found to decrease ED visits indirectly due to improved discharge teaching quality and discharge readiness. ■

Evidence-Based Medicine: The Present and Future of Hospital Care (continued from page 1)

be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence."

While many hospital and health systems have already implemented evidence-based medicine and processes of care, there are still several challenges chief medical officers will have to face, ranging from full updates of evidence, technology and support from hospital and other clinical leadership.

Critics of EBM are usually either patients or physicians — some patients trust their own physician more than guidelines, and some physicians might feel slighted that technology and outside sources are influencing their own clinical decisions. However, EBM is more than just technology and gathering evidence-based research, says James Leo, MD, medical director of best practice and clinical outcomes for MemorialCare Health System in Fountain Valley, Calif. "The purpose of evidence-based medicine is not to remove the 'art of medicine,' but rather to ensure that in the midst of practicing one's art, the known science regarding optimal management of an individual patient's condition is applied reliably and consistently," he says.

Previously, Dr. Leo was the associate chief medical officer at Long Beach (Calif.) Memorial Medical Center, one of six MemorialCare hospitals, and has helped lead a national effort to use predictive modeling, benchmarking and EBM to improve hospital care. Evidence-based practices shouldn't be looked at as "cookbook medicine," he says. It should be embraced because, in the end, it can help physicians deliver a higher level of care.

Players that need to be involved

Like any major decision at a hospital, the senior leadership must be on board. Dawn Vande Moortel, RN, MS, director of clinical training for Milliman Care Guidelines, says senior leadership of the organization has to give the appropriate support for EBM, and from there, case management departments, nursing leadership and physician leadership all need to work together to have a dialogue around the EBM and how to apply the guidelines to their daily work.

When it comes to the physician and nursing leadership, a hospital's CMO and chief medical information officer are integral in a hospital's transition to EBM. Dawn Walters, RN, assistant director of nursing at The University of Kansas Hospital in Kansas City, adds that the nursing informatics team also plays an important role as they give clinical input from a different point of view.

The basics of EBM

EBM, simply put, is the combination of clinical expertise, patient preferences and the best research evidence to help the decision-making process for patient care. Evidence-based guidelines and sets can be found from numerous sources, and the overall goal is to aggregate the best data and use the conclusions to help come to a clinical decision. For example, a patient might be dealing with heart failure. Clinicians can pose a question and look for interventions to help the patient (does the patient need surgery, tests or prescription drugs?). Then after comparing it to other scenarios and research, clinicians outline their desired outcome and make a decision on how to treat the patient based on the process they just conducted. "When you are using the evidence-based source of information to manage care, you're going straight to the literature," Ms. Vande Moortel says. "It's not consensus opinion based on one or two practitioners. You're using the best possible approach to care management."

EBM also touches every specialty within a hospital setting, Dr. Leo says. Whether a patient has a risk for formation of blood clots that can break off and travel to the lung (involving numerous specialties) or whether a patient has a specialty-focused problem, such as coronary artery disease, physicians can find research on almost any condition and patient demographic. "Between global recommendations regarding hospital care and specialty-focused practices, there is literally no patient whose care cannot be positively impacted by evidence-based practice," Dr. Leo says.

For example, The University of Kansas Hospital recently went live with 240 evidence-based order sets deployed via computerized provider order entry, and the frequent updates of the evidence in their processes of care has helped them "to standardize patient care and ensure optimal patient outcomes," says Greg Ator, MD, CMIO for KU Hospital.

Best practices and challenges

Before a hospital decides to implement EBM, the leadership needs to assess the current clinical practice, how the clinical work has been accomplished thus far and what the organization is interested in accomplishing with EBM as the new foundation, Ms. Vande Moortel says.

After a hospital knows its general clinical direction, it can look to develop its evidence-based sets and processes of care. The development of tests and measures for evidence-based sets most commonly occurs at the health system level of larger organizations, and then the implementation of those tests and measures is delegated to the CMO at each hospital, Dr. Leo says. However, he adds that a successful transition to evidence-based practice must be multidisciplinary and inclusive.

For example, Dr. Leo notes that MemorialCare established an organization of physicians to implement EBM called the MemorialCare Physician Society. There are 13 "Best Practice Teams" chaired by a physician expert in the specific medicine covered by that team, and team membership consists of interested physicians, nurses, pharmacists and other healthcare providers for each specialty (e.g., cardiology, emergency medicine, women's health, neonatology, etc.). "It's our goal to ensure every team has at least one physician representative from each of our hospitals, preferably more than one," he says.

From there, the teams develop evidence-based protocols, and the protocols then undergo a comment period for recommended changes and input. "The sole requirement is that any recommended changes must be evidence-based, and the evidence needs to be submitted with the comment," Dr. Leo says.

After a hospital finds its direction and inclusively creates its order sets, how does a clinician actually access them? Electronic health records are becoming mainstream, and Dr. Leo says EHRs could easily make the practices accessible. For example, MemorialCare has built the evidence into its inpatient and ambulatory EHRs as well as the rules and alerts that help prompt the clinician to their use. Clinicians can simply click on embedded links to see the literature and rationales.

However, there are concerns of an overdependence on technology being fused with clinical decisions. Some have wondered what happens if the gathered research and technology medium create an error. Dr. Ator refutes that point, though, saying if hospitals and clinicians take all the right steps and do everything by the book, EBM is seamless. "Computers don't make mistakes," he says. "Humans who make computers and humans who input data into the computers make mistakes."

EBM has been a large part of the modernization of today's healthcare, and many see it becoming widespread in the future as more emphasis is put on taking the time to find the right diagnosis and enacting quality care to eliminate chronic illnesses. "If we're getting into a value-based system, the accountable care model, accountable care requires accountable providers, physicians, nurses, ancillary services to be looking to the evidence for the standard of care," Dr. Ator says. ■

Believing in Quality Care and Delivering It: Q&A With UPMC's Chief Quality Officer Tami Minnier

By Molly Gamble

Tami Minnier, RN, MSN, chief quality officer at University of Pittsburgh Medical Center, will tell you the simplest things often generate the most excitement and change. Since assuming her position in 2008, Ms. Minnier has been a key leader in UPMC's safety and quality innovations and also successfully led the system's hospitals in Italy and Ireland through the Joint Commission International accreditation process.

"It's an amazing time to be involved in the quality and safety of healthcare today. It's always mattered, but today it matters even more," says Ms. Minnier, who took time to discuss fearlessness and risk-taking, the secret to success when working with physicians, the importance of clinical evidence when working with CMOs and healthcare quality on an international scale.

Q: What skills, communication strategies or leadership tactics have you found to be most critical or effective in quality improvement initiatives?

Ms. Minnier: When you step back and think about skills and tactics, I think one thing that has made UPMC successful is our willingness to speak what's right. It's the ability to be transparent, to state expectations, put the patient first and fully believe in arguments around why that patient needs to be first. It sounds so simple. Skills matter, but what really matters is courage — the courage to say, "No, I hear what you're saying, but I really think we need to go in this direction."

Courage and risk-taking make the most difference between an organization that is willing to talk about safety and quality and an organization willing to do [something about] it. You can learn these things, but [leaders] have to put money where [their] mouths are and jump in. These leaders are willing to speak out, to have courage, take risks and even be disruptive at times.

Q: How do you boost or maintain physician involvement in quality/safety improvements?

Ms. Minnier: We begin with a very strong core value. Fundamentally, every physician cares about quality and safety. Through busy careers, patient volume and activities, they might not have the time to stay actively engaged in quality. Our quality model helps them stay engaged. We have improvement specialists, staff with clinical backgrounds but also skills in quality improvement and safety. We partner them with busy physicians, and they give physicians some pieces of infrastructure to engage them. The physicians need that partner to help make [quality initiatives] come to life.

Part of our success is recognizing that everyone believes in it, but how do you deliver it? Our quality symposium, which is coming up on Oct. 3, will feature the more than 100 physicians who are working with improvement specialists to deliver quality or safety goals. A few years ago, that number might have been 20 or 30. We've given them the platform to succeed.

Q: How can the CMO take on a more active role in quality/safety improvements? Are there any aspects of quality the CMO can accomplish through their role that other chiefs might not be able to influence as strongly?

Ms. Minnier: The CMO is an extremely critical role in most organizations today. Every CMO role is a little different in each culture, but all CMOs care about quality and safety and drive home those improvements. To get them to be more actively involved, one of the things we've found successful is to provide them with the information to have the conversation. We're data rich and information poor. [This industry] is still building the infrastructures that are necessary that other industries have had for years.

It makes a difference when I can give a CMO good information on a clinical practice, and they can talk to practicing physicians. We're giving them the infrastructure to succeed (just as we've done with our physicians), which is solid, factual information that helps them.

This is the greatest secret about success: physicians are scientists. They are used to analyzing information to make decisions about patients. You don't want to go up to them and say, "Oh, I have an issue, can you help me fix it?" You want to say, "I've looked at this analysis, and I've looked at this information, and now I need your help finding out what it means."

Q: A recent survey by Thomson Reuters found quality improvements to be the top priority of hospital CEOs. Do you think quality improvements have a more prominent role in healthcare administration today compared to years past?

Ms. Minnier: I do think quality is much more of a priority. I mention my boss, Elizabeth Concordia, president of our Hospital and Community Services Division, often because she is the driver of this work in our hospitals. Nationally, I think value-based purchasing, whether you like it or not, [has made a difference].

For less enlightened organizations that haven't put quality as a cornerstone of their functioning, VBP pushes them to do it. So whether you've been pushed or ran towards it, all hospital CEOs are paying more attention to this topic than ever before. They're seeking more guidance from quality staff, national experts and others.

Q: What are your thoughts on quality now being tied into payments?

Ms. Minnier: I firmly believe that certain metrics should be tied to payments. I think the most important points I have caution around are this: Let's not make so many metrics that the metrics matter more than the patient. In two years, I'll have more than 100 things to measure.

We've got to be cautious about how quickly we grow and how many measures we add. We're moving an enormous system in the United States. It's a big job, and an important job that takes time. I just don't want to lose the good by trying to push so fast that it becomes about checking off a box. There are unintended consequences of measuring something, and there's a difference between checking a box versus doing the right thing.

It's a fine line between how quickly and how many metrics you tie to performance versus how many will stimulate change. I think it's an issue of the number [of metrics]. Now, realize, I can see the other side of it — there is so

much evidence in literature that the healthcare industry has yet to adopt into practice.

I appreciate our regulators' sense of urgency about quality of care. But that has to be balanced against how much a system can still tolerate in change while maintaining success. I don't mean to be critical of it, I just think we need to be thoughtful of what we add to this matrix in the future. We should add [metrics] that can save people's lives and reduce mortality rates.

Q: How does UPMC approach quality measurements or benchmarks? How are these figures communicated with staff, and how do you break goals into manageable processes?

Ms. Minnier: We measure everything you can imagine. We use benchmarks a lot, and we firmly believe in benchmarking our performance. Certain benchmarks are easy to get our hands on, like CMS measures, patient satisfaction scores, and Joint Commission measures. The more clinical you become, the harder it is to get data. So you start benchmarking yourself against yourself.

We use benchmarks to stimulate improvement. We'll look at other scores and say, "Well, we're here. They're there. Wonder how we're different? How could we get better?" So we call people, we engage and we learn from many people across the country. We try to bring processes back and engage our clinical leadership to improve at UPMC.

Every benchmark has a process behind it. If your emergency department throughput is the best in the country, then why are you so successful? Is it your triage to treatment time? We want to break this down, make it very granular. Then we use fancy tools, like Lean or Six Sigma. There's a science to improvement that we firmly believe in and use, but we don't run around and talk about it. We teach others as we go, and we use different tools.

Q: Can you share any exciting developments or news that is happening at UPMC in terms of quality?

Ms. Minnier: We have so many things going on. One new innovation is our reliable and variable rounding system for nursing care delivery. Nursing assistants are intended to do basic things, like bathe the patient and help them to the bathroom. From a patient perspective, those are very important jobs. Many times, when it comes down to a patient's perception of care, they judge the nursing assistants' jobs quite a bit.

Healthcare has traditionally never approached nursing assistants in a structured, organized way. By bringing in the principles of the science of reliability, we recognized that there is work that needs to happen on a nursing unit that is very reliable and very predictable. People need their water pitchers filled. People need to be turned and repositioned in their beds. People need meals fed to them. Then there is variable work — a patient needs an X-ray, or a patient has suddenly been discharged and needs to go home. We've been trying to mix that work, but you just can't.

It's been two years since we started a completely new care delivery mode. We're an early adopter of this model, which separates the work of nursing assistants into reliable rounders and variable rounders. We have a ton of early data to show how much we've improved how frequently patients see nursing assistants, how much they're turned, how much they walk and how much happier they are.

Q: It seems like an innovation that is so simple it makes you wonder why no one has thought of it before.

Ms. Minner: Yes, exactly. We're super excited about this innovation, and this new way of thinking about nursing care delivery in healthcare. It really shows how you can change healthcare by using principles from other industries. The stuff that is most innovative and creative is not sexy, advanced technology — it is simple sense. The things that excite me most tend to be the most basic. ■

Healthcare Reform and Opportunities for Performance Improvement: How to Use Data to Incent Physicians, Change Behavior

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

The Congressional Budget Office in June 2010 stated, "slowing the growth rate of outlays for Medicare and Medicaid is the central long-term challenge for federal fiscal policy." This imperative is driving healthcare policy and will affect every hospital's strategy concerning Medicare patients and the hospital's relations with their physicians. As the federal agencies introduce programs aimed at reducing cost while maintain or improving quality, health systems must respond intelligently and adapt their strategy and business plans to fit within new healthcare delivery models.

The federal government, through the Patient Protection and Affordable Care Act, has designed three specific initiatives to improve quality and control costs: the Medicare Shared Savings Program, which establishes Medicare accountable care organizations; the Bundled Payments for Care Initiative, which expands CMS' Acute Care Episodes; and Consumer Operated and Oriented Plans. ACOs and bundled payments are oriented primarily at the Medicare population, but CO-OPS extend beyond that. They are defined by the PPACA as non-profit insurance companies that would allow "consumers" — which include providers — to compete directly with traditional medical insurance companies.

While not all health systems may choose to develop ACOs or CO-OPs, it is our belief that all hospitals that treat Medicare patients will ultimately be required to accept bundled payments. Under the Bundled Payments for Care Initiative, hospitals must apply to participate, receiving global or bundled payments — one payment to be shared between the hospital and physicians for a specific episode of care or predetermined period of time — from CMS if accepted. For the purposes of this article, we'll refer to these payments as global budgeting efforts. However, if the initiative is successful at lowering costs while maintaining quality, we expect bundled payments to eventually become par for the course for Medicare providers.

As hospitals are contemplating their responses to global budgeting or these other risk-sharing initiatives, the questions that need to be answered are similar. Based on the physicians' and hospitals' quality outcomes, what percentage of the reimbursements should be shared with the medical staff? How can hospital administrators help physicians improve clinical outcomes to maximize the enterprise's collective reimbursements? What percentage of dollars should be allocated for each of the clinical services based on their group's outcomes? Which outcomes should be measured to determine quality improvements?

Providers must prepare themselves to thrive on fewer dollars as global budgeting in all of its forms is implemented by CMS and other fiscal intermediaries. For provider enterprises that are prepared, this represents an opportunity that is long overdue — financially incenting physicians on the basis of clinical quality and cost efficiencies outcomes. If providers take advantage of the recently enacted federal initiatives and specific provisions of the PPACA, physicians will retain control of their clinical decision-making prerogatives and prosper financially along with their hospitals.

Opportunities for performance improvement

Success under global budgeting will require hospitals to be armed with data to drive performance improvement and track physician performance on quality and cost indicators, which then can be used to determine payments. Even if a hospital is not yet accepting bundled payments, access to this data can be used to improve quality and reduce costs in preparation for new healthcare delivery models, which will be based on value.

Hospitals will need to analyze medical records data to create severity-adjusted patient-level data and implement physician-directed, best practice improvements. The process should involve aggregating at least three years of a hospital's all-payor data and using the risk-adjusted information in order to compare providers' practices and patient outcomes whose severity levels are relatively the same. Key metrics for hospitals to derive from this claims data include mortality and morbidity rates, average charges and length of stay norms for the hospital overall as well as by service line and by diagnosis-related group. These norms should then be shared with each physician, along with data on his or her outcomes. The process should be entirely educational and non-threatening. Physicians are seldom aware of the significant variations that are present in their practice patterns, and these techniques represent the opportunity to identify those patients with the highest quality, most cost-efficient outcomes. The clinical and operational processes that produced these superior outcomes can then be replicated as templates for future continuous improvements.

Next, physicians guided either by an internal or external facilitator should review the care with the best outcomes to identify best practices to include in clinical pathways. For those patients with less effective care, hospitals should work with the patients' physicians to determine if there were clinical and/or organizational issues that could have created the observed inefficiencies or quality problems. We recommend engaging each physician on a one-to-one basis to discuss his/her variations in practice, their consultants or other issues that might be contributing to any observed inefficiencies. A plan should then be developed to make changes that the physicians determine to be appropriate. Here, it is important to allow the physician to lead the charge (hence the name of physician-directed best practice improvements) rather than to dictate changes to the physician. The best demonstrated clinical and operational processes are then incorporated into clinical pathways to be used for future patient care and computerized physician order entry implementation to continuously improve clinical and operational outcomes.

Transparent metrics of quality for all stakeholders

In order to keep providers engaged in quality improvement efforts, data shared with physicians must be transparent and easily comprehended. This can be challenging as there are many performance metrics that must be tracked. We recommend hospitals share and track at least six of the most clinically and fiscally relevant quality indicators (as identified below) over a three-year period to better track trends and improvements. Verras recently developed the Index of Quality Improvement to do just that. The IQI uses an 800-point scale that is analogous to the Dow Jones or other financial indices.

The six indicators of quality that comprise the IQI are:

1. **Resource Consumption,** measured by the inflation rates of hospital charges over a three-year period (charges as a surrogate for resources consumed).
2. **Morbidity Rates,** measured by excessive lengths of patients' stay and averaged over three years.
3. **Mortality Rates,** for the top 10 major diagnostic categories over three years.
4. **Reductions in Variation,** for the top 10 DRGs, which constitute the majority of a hospital's patients.
5. **Patient Satisfaction,** as reported to the federal government.
6. **National Hospital Quality Measures,** as reported to the federal government.

Hospitals may also opt to include a seventh indicator for accountable care organization measures, which encompasses the 65 quality metrics that ACOs must report. If a hospitals selects to include this indicator, the total IQI point scale is then increased to 1000 points.

By tracking performance improvement indicators and presenting them in a straightforward manner, hospital leaders can more easily determine hospital and physician financial, gain-sharing rewards as well as demonstrate to their local employers and patients the quality and cost efficiencies they are delivering to their communities

Summary

Using a data-driven, change management approach to implement physician-directed best practices is an extremely effective means of improving providers' clinical quality and cost efficiencies. When these proven techniques are augmented with physicians' financial incentives within global budgeting or other at risk-bearing structures, hospitals and physicians will thrive even in an environment of ever diminishing Medicare and Medicaid reimbursements. Basic methods of quality improvement as described here will be the optimal means of implementing healthcare reform, far outstripping top-down mandates by governments, institutions or cross-industry consortiums.

By reducing variations through statistical analysis, continuous quality improvements can be implemented that reduce resource utilization, increase throughput, lower costs, minimize errors and improve patient outcomes. Moreover, when physicians are reimbursed on the basis of verifiable, superior outcomes, hospital enterprises will move healthcare reform forward and benefit all stakeholders. ■

Basic Infection Prevention Saved Children's Hospitals $104M Over 5 Yrs

By Jaimie Oh

Over five years, Johns Hopkins Children's Center and 87 other pediatric hospitals have saved hundreds of patient lives and more than $100 million with basic infection preventions.

The results are from an ongoing national pediatric quality improvement program launched in 2006 and spearheaded by the National Association of Children's Hospitals and Related Institutions. The steps for the quality improvement program include daily assessment of the need for the line, regularly changing the dressing covering the device, cleaning the line before and after use and hand washing before handling the line.

Comparing current infection rates with infection rates before the program's 2006 launch, experts estimate that the initiative has so far prevented 2,964 central line infections, saved 355 children's lives and saved nearly $104 million that would have gone toward treating complications stemming from invasive blood-stream infections. Experts estimate each infection carries a price tag of up to $45,000. ■

Advocacy Groups Ask Congress to Make Hospital Accreditation Surveys Public

By Lindsey Dunn

Around 50 healthcare advocacy groups across the country are asking Congress to require hospital accreditation surveys to be made publicly available.

The groups sent a letter to Sen. Tom Harkin (D-Iowa), chairman of the Senate Committee on Health, Education, Labor and Pensions, urging him to support legislation that would make accreditation surveys public.

Private accrediting organizations, such as The Joint Commission, accredit hospitals as part of their requirements to participate in federal healthcare programs. ■

AHRQ Initiative Aims to Foster Better Communication Between Clinicians and Patients

By Jaimie Oh

The Agency for Healthcare Research and Quality, in partnership with the Ad Council, has launched an initiative to encourage clinicians and patients to engage in effective two-way communication to ensure safer care and better health outcomes.

This new initiative builds on previous public education campaigns AHRQ has conducted under contract with the Ad Council around the theme "Questions are the Answer." This phase of the initiative features new public service ads directed at clinicians with the message that a simple question can reveal as much important information as a medical test. Research shows that better communication correlates with higher rates of patient compliance with treatment plans.

The new ads for clinicians will run in donated space this fall in a variety of print and online medical and allied health journals, including the *New England Journal of Medicine* and the *Journal of the American Medical Association.*

AHRQ's website also features sources to help patients be prepared before, during and after their medical appointments. ■

HHS Removes Public Access to Physician Malpractice Info

By Jaimie Oh

The Department of Health & Human Services has shut down public access to its National Practitioner Data Bank, which holds information about healthcare providers such as malpractice histories.

The National Practitioner Data Bank houses confidential information used by state medical boards, hospitals and health insurance companies to grant privileges or licenses. The data includes identifiers as well as malpractice histories and disciplinary actions taken against each healthcare practitioner.

Public access to these records has been limited: Consumers were able to view records, but identifiers such as names and hospitals are removed. For increased security, the database also did not specify age or dollar amounts of malpractice settlements, rather using ranges such as age 40 to 49, according to the report.

HHS said it shut down public access to the database due to the media's ability to "triangulate" the confidential data with court records to find out otherwise classified information. "We have a responsibility to make sure under federal law that it remains confidential," an HHS spokesperson said.

HHS may re-establish limited public access of the data after a "thorough analysis of the data field," according to the report. ■

Harnessing data to improve performance and reduce clinical variation can help you redefine the cost-quality equation.

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