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INSIDE

Is CMS penalizing top performers?

Study finds good performers more likely to be dinged

The world of quality metrics is supposed to be coalescing around data that all stakeholders agree leads to higher quality care, better outcomes, and improved patient safety. But according to a study in the July 25 issue of the *Journal of the American Medical Association*, hospitals that do well in a variety of quality metrics and those that are accredited by The Joint Commission or other accrediting organizations are more likely to be found wanting in the CMS HAC Reduction Program and are more likely to be penalized 1% of their Medicare reimbursement for poor performance.

"THE AUTHORS CREATED AN EIGHT-POINT QUALITY SCORE BASED ON ITEMS THAT HAVE BEEN SHOWN IN PEER-REVIEWED LITERATURE TO RELATE TO HIGH-QUALITY CARE.

The authors created an eight-point quality score based on items that have been shown in peer-reviewed literature to relate to high-quality care. One point was awarded for each of the following[1]:

1. the highest quartile of inpatient admission volume,
2. accreditation by The Joint Commission,
3. accreditation by the Commission on Cancer,
4. whether the facility provides transplant services,
5. level of trauma center,
6. the highest quartile of nurse-to-bed ratio,
7. membership in the Council of Teaching Hospitals, and
8. participation in a clinical surgery registry.[1]

Along with this eight-point score, the authors looked at Hospital Compare data related to

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outcomes and process of care measures for pneumonia, heart failure, surgery, and heart attack patients. The measures from those included in the study were[1]:

1. For heart attack patients, those prescribed a statin at discharge.
2. For heart failure patients, those who received discharge instructions, and those with left ventricular systolic dysfunction who received ACE-inhibitors are angiotensin receptor blockers.
3. For pneumonia patients, those given the right initial antibiotics.
4. For surgical patients (depending on the type of surgery performed), preoperative beta blockers continued post-surgically, prophylactic antibiotics discontinued within 24 hours of surgery, and/or catheter removed within two days post-operatively.
5. Outcomes measures included 30-day mortality rates used in the CMS Value-based Purchasing Program for acute myocardial infarction (AMI), heart failure, and pneumonia in 2015.[1]

The composite score and the measures from Hospital Compare were used to compare hospitals with the list of those that were penalized under the HAC reduction program — 721 of the 3,284-plus hospitals studied by the authors. The characteristics of the penalized facilities were shocking:

- Larger hospitals (35.4% vs. 13.5%)
- Those accredited by the Joint Commission (24% vs. 14.4%)
- Those with the highest nurse-to-bed ratio vs. lowest (29.3% vs. 17.4%)
- Level 1 trauma center vs. non level 1 (47.4% vs. 19.1%)[1]

To continue the counterintuitive findings: 17% of non-teaching hospitals, 42.3% of major teaching hospitals, and 62.2% of major teaching hospitals were penalized, the authors found. Hospitals with more complex patients to care for were also more likely to be penalized.[1]

The quality summary score that authors gave to hospitals, which is based on items long-held to signal quality, also showed an inverse relationship to penalties under the HAC reduction program. "Although hospitals with higher hospital quality summary scores had better performance on 9 of 10 publicly reported process and outcome measures evaluated," the study notes, "they were penalized significantly more frequently in the HAC Reduction Program than those with lower hospital quality summary scores."[1]

The big question is why. The authors suggest that the HAC program doesn't reflect the poor quality it seeks to change, and that there could be issues with the metrics selected and problems within some of the specific measures.

Among the concerns they mooted in the report: surveillance bias — those hospitals that are looking for problems like venous thromboembolism (VTE) are more likely to find it, and the more cases you find, the more likely you are to be penalized. In addition, the hospitals most likely to find more cases of VTE are those accredited by The Joint Commission (or any other accreditor), those who have a good nurse-to-patient ratio, and those with a higher complexity of patient.[1]

Similarly, those hospitals that participate in surgical registries may have more robust standardized procedures for gathering data and identifying adverse events, which makes them more likely to be penalized, the authors say. Another

element could be that very small hospitals with few discharges in specifically targeted conditions don't have their own data used, but a national average, which makes them look better, perhaps, than they are, and larger hospitals worse.[1]

"We suspected there were some issues with the program, but the findings were surprising," says study author **Karl Bilimoria**, MD, MS, vice chair for quality for Northwestern Medicine and director of the Surgical Outcomes and Quality Improvement Center at Northwestern University Feinberg School of Medicine in Chicago. "We did not expect there to be such a paradoxical relationship between factors reflecting hospital quality and penalization in the HAC Reduction Program. It may actually be capturing the inverse of quality."

If the HAC isn't capturing quality, but instead has a set of flawed measures that are merely leading hospitals to incur penalties, what should quality departments do?

Bilimoria says that they should take a closer look at the issues raised in the study and "see if you aren't simply chasing metrics and employing time-consuming quality improvement efforts where you don't really have a problem."

Whether CMS acts on this information remains to be seen.

For more information on this topic, contact Karl Bilimoria, MD, MS, Vice Chair for Quality, Northwestern Medicine, Director, Surgical Outcomes and Quality Improvement Center, Northwestern University, Feinberg School of Medicine, Chicago, IL. Telephone: (312) 695-4853. Email: k-bilimoria@northwestern.edu.

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CMS finalizes two-midnight rule

RAC changes included

Last month, *Hospital Peer Review* included breaking news about the finalized Outpatient Prospective Payment System (OPPS) rules that included updates to the two-midnight rule that has so plagued hospitals, as well as changes to the recovery audit program that many felt was slanted toward the auditors, with an incentive to find fault and no incentive to resolve disputes quickly.

The changes in the OPPS are supposed to give physicians more flexibility to determine which patients might be considered an inpatient, even if they don't stay over two midnights.

"I don't think we can tell if it will be an improvement or not," says **Ann Sheehy**, MD, MS, an associate professor in the department of medicine and the division head of hospital medicine at the University of Wisconsin Hospital in Madison. That the CMS maintained it, but gave some flexibility to physicians to allow patients to stay longer than one midnight, but less than two and still be an inpatient, seems great on the surface, she says. However, "the rule may be hard for hospitals to operationalize."

The new rule also relies on "physician judgment," but many doctors may wonder whether that will truly be honored, Sheehy says. "And it's still unclear if even two midnights will hold as an inpatient." During the recent Medicare Administrative Contractors (MAC) Probe and Educate period, she says there were nine cases reviewed at the University of Wisconsin, and three were initially denied. "All three denials spanned two midnights, and the reason for denial was that our documentation did not support the need for two midnights of care."

Sheehy says they have contested these cases, but "it remains possible that even two midnight inpatient stays will be challenged when true auditing returns." Recovery auditors have been on hiatus for almost two years, she says, so how the rule will be enforced on their return is unclear.

She has a deal of skepticism about how the proposed rule will work in practice, saying it will depend on how it is audited, and how well in turn CMS supervises its auditors. "We know that auditing is necessary in the Medicare program because there is fraud and abuse out there. However, we have generally felt that the Recovery Audit program itself needs to be better regulated, and would benefit from greater transparency in data reporting so that CMS and Congress

could see some of the flaws that we see on the hospital level."

CMS has now made Quality Improvement Organizations (QIOs) the first line of review, she says, and they have largely focused on improvements in clinical care, rather than billing determinations to date. "That is the work they will be asked to do monitoring outpatient and inpatient status determinations, so it is unclear how they will adapt to this new role. It appears that QIOs are not contingency fee-based, which should in and of itself make them a more effective and fair auditing body."

The contingency fee system is a structure that needs to go, Sheehy says. She points to Senator Debbie Stabenow's (D-MI) amendment to the Senate Finance committee draft bill, the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (see the full bill at http://1.usa.gov/1MSr2mP), as a good example of the kind of correction she's talking about. "We also need improved transparency in Recovery Auditor data reporting, as stated in Senator Ben Cardin's [D-MD] amendment to the same bill, which passed the finance committee in June. With improved transparency in data reporting, Congress and CMS would be much better able to target problem areas in the Recovery Audit program."

The problem she sees with the entire focus on observation versus inpatient status is that it has absolutely nothing to do with quality of care. "It's a billing distinction," she says. "We recently published our audits data from the University of Wisconsin, the University of Utah, and Johns Hopkins Hospital. Of over 2,500 Complex Part A denials, not a single denial disputed the quality or necessity of care delivered; rather, every denial contested the billing status, inpatient, or outpatient." *Hospital Peer Review* looked at that study in the June issue.

"Even though the proposed rule utilizes QIOs," Sheehy continues, "I do not see this resulting in improved patient care if they are also tasked with surveying billing status."

Overall, she believes that CMS had good intentions, both with the original two-midnight rule as a means to curb the growing number of long observation stays, and with this proposal to remedy the issues that arose when that rule was implemented. "Part of the problem has always been what CMS intends and how a rule is actually audited. I do not think CMS has done a good job monitoring its auditors, and the contingency-fee payment recovery audit structure has led to overzealous auditing that I don't think has been beneficial for patients, providers, hospitals, or CMS. Unfortunately, I don't think any rule CMS issues will be successful without improved transparency and accountability in the audits system."

Enforcement of the two-midnight rule resumes on September 30. The complete final rule can be found at http://bit.ly/1MYaYwN.

For more information on this topic, contact According to Ann M. Sheehy, MD, MS, Associate Professor, Department of Medicine, Division Head, Hospital Medicine, University of Wisconsin Hospital, Madison, WI. Email: asr@medicine.wisc.edu. ■

Enhanced recovery comes to America

Euro method shows great promise for surgical patients

While the United States likes to think it is at the forefront of all things medical, there are some things in which we are very conservative and in which we lag. For years in Europe, surgeons have been following a protocol for surgical patients, called Enhanced Recovery Protocol, that involves letting them drink until two hours before surgery, getting them moving as soon as possible after, and using non-opioid pain killers as much as possible.

The results from this method was uniformly shorter stays, lower costs, fewer complications, happier patients and happier doctors. But here in America? The idea wasn't taking off very quickly.

Traci Hendrick, MD, FACS, an assistant professor of surgery at the University of Virginia Health System in Charlottesville says she heard the method talked about a few years ago, in particular by a colorectal surgeon out of Mayo Clinic in Minnesota. "He presented his findings at a conference and it was just mind-boggling how well his patients did," she says.

After talking it over with an anesthesiologist at the UVA's 600-bed academic hospital, they spent about eight months developing a protocol using

the tenets of enhanced recovery as developed in Europe.

They start with teaching for the patient that includes checklists of what will happen when, that the patient is encouraged to use to hold the medical staff accountable for what will happen. Anesthesiologists use spinal blocks rather than opioids during and after the operation. Patients are allowed to eat right after surgery in an effort to get their bowels moving again quickly.

"I knew from the first patient that our results would be good," Hendrick says. "Usually, a patient is in the hospital after colorectal surgery for five to 10 days. The first three or four the patient looks awful and feels awful. The bowels have shut down and we're giving morphine, which doesn't do anything to help get things moving. Meanwhile, you hadn't eaten since midnight before surgery, and if you were unlucky enough to have afternoon surgery, you're starving, but you aren't given any real food until your bowels move again, which they aren't doing because we're giving you all this morphine and not letting you move around. We know that those things together can lead to a lot of side effects."

Elderly patients might become delirious, or they may vomit. Everyone is groggy throughout most of their stay, she says.

Under this protocol, though, patients can drink fluids within two hours of surgery and are encouraged to "carbo load" with an electrolyte drink. They are allowed to eat as soon as they awaken, are not given opioids if something else will work, and are out of bed as soon as possible. Hendrick says the difference in affect among the patients is amazing. They look less like death warmed over, and more like someone who just woke up from a nap. They aren't groggy or listless. They are in a better mood.

The cost savings are significant. In a study of 207 patients, Hendrick found length of stay declined by two days, and IV morphine use was also considerably down, Hendrick says. Complications were down 17% over the course of the study, and patient satisfaction with pain levels improved by more than 50%. The average cost per patient declined by more than $7,100.

A lot of hospitals just pump fluids into patients without consideration of what the patient actually needs, Hendrick says. Their protocol uses a meter on the patient's finger to tell them exactly how much fluid to push into a patient during surgery, leading to a decrease of about two liters per patient per surgery.

She says that while this is a "dramatically different way to care for patients," and that "we are all often very set in our ways," the data surrounding ERP is so strong she would bet that within five years this will be the standard of care, at least in colorectal surgery. "Although we are using it here in orthopedics and gynecology, too."

She says that getting her anesthesiologist on board, creating a protocol, and presenting the data to physicians was instrumental in getting people to accept this radical change. "I think that's the best thing about this: We are all working more as a team now."

For more information on this topic, contact Traci Hendrick, MD, FACS, Assistant Professor of Surgery, Section Colon and Rectal Surgery, UVA Health System, Charlottesville, VA. Email: TH8Q@hscmail.mcc.virginia.edu. ■

Looking at the in-between moments of care

New certification from TJC for integrated care

For years, healthcare has known that handoffs can make or break patient care. A good one can mean an elderly patient doing well post-hospitalization. A bad one can mean that same person returning multiple times to multiple facilities for multiple problems.

Now, a new certification offered by The Joint Commission focusing on integrated care could help facilities perfect their handoffs between levels of care, something that is particularly important as the Affordable Care Act requires inpatient, outpatient, and other community care providers to work together to maintain population health, says **David Baker**, MD, the executive vice president of the commission's Division of Healthcare Quality Evaluation.

"Healthcare is changing and everyone is trying to develop an integrated healthcare system," Baker says. But as they look at these supposed systems, what they are finding is that they may be individually great hospitals, medical homes, and skilled nursing facilities,

but they don't necessarily work well together. "This certification is to help them think about what it means to be truly integrated, not simply affiliated with each other."

The pilot certifications often resulted in entities finding that what they thought was integration was something less than that, he says. "We will help them walk the walk."

Until a few months ago, Baker was the chief of general medicine and geriatrics at Northwestern Hospital and worked to created real integration within that system. "When we started the hospitalist program in 2003, my office was 100 yards from the emergency department. But I could have real issues with communication."

Within a few years, they created a system where there was an immediate email to his office if one of his patients showed up in any part of the Northwestern system, whether the patient was conscious or not. "I would get a page and see where that patient was admitted, and then eventually, to where I could go into the electronic record and read the admitting physician's notes, any notes from the emergency department. I could see if any critical information that I knew of as the primary care physician was missed — something about the social history, for instance — and include that. That was revolutionary. That was true integration."

This is the kind of powerful change that the commission wants to foster through the program. The process initially involves just ambulatory and hospitals entities, with eventual progress to post-acute care facilities. One of the two entities involved must be Joint Commission certified.

"We know that big quality problems seem to happen at the seams, and since accreditation looks at problems within the organization itself, we didn't want to be redundant," he says. So this certification looks at the connections: the discharge process, the admissions process, and communications such as expect notes from the primary care physician to the emergency room.

There are some clinical processes and quality measures that cut across both the general quality of a hospital, as well as these handoff situations, says Baker, and these, too, will be examined. For instance, at Northwestern, one issue that the integration of the system found was that patients with colorectal cancer surgery were not always getting appropriate chemotherapy treatments. "If you are truly integrated, you will have in- and outpatient teams working together to find out how many of those patients achieve optimal care. The same with other cancers, such as breast cancer. Then you would work to fix any problems."

Another example comes from cardiology, where literature shows that only half of heart attack patients are still taking their appropriate medications six months after discharge. That's not something that has been in the purview of hospitals before, Baker says. But as hospitals and practices begin taking joint responsibility for the health of patients, knowing who is and who isn't doing what the inpatient specialists say they should be doing six months out is something that might benefit everyone, most especially the patient.

"Heart failure patients getting great care after two or three months, once that 30-day window has closed is another area where the two areas can really cooperate."

Surveyors will assess how the hospitals and outpatient facilities will work together as patients move from one setting to another and back again, he says. "Using the tracer methodology, which has been a long-standing cornerstone of The Joint Commission's on-site survey process, surveyors will evaluate how well an organization integrates information-sharing, transitions of care and hand-off communications, as the patient moves from the hospital through the continuum of care. Although the surveyors will not evaluate the actual care delivered at each site, the surveyors will visit various sites to assess the level of integration, using principally tracers, staff interviews and patient interviews."

Readmissions continue to be a big issue for patients, payers, and the organizations that face increasing penalties for unplanned returns to hospital says Baker. By helping organizations learn to pass patients from one place to another with all the right information might just be one of the missing pieces to really tackling this long-standing problem. And by getting these different kinds of organizations to work together, they just might find issues to address the problem they hadn't thought of before.

For example, Baker wonders how many organizations know that their discharge summaries get to the appropriate ambulatory providers within 48 hours. "This was an issue at Northwestern," he says. "If you are at 95% a week, that doesn't tell me what I need to know at day three about that sickest patient who comes in to see me. You need to have a way of saying, 'This is on the electronic record within this amount of time.'"

Another thing that you might discover working together is

something that shocked Baker at Northwestern: a supposedly integrated system. Just half of the patients discharged from one of the hospitals was seen at one of the clinics within two weeks, he says.

Given that there is ample evidence that seeing a primary care provider within two weeks of discharge is a key metric for preventing unplanned readmissions, Baker says this is another metric that a hospital needs to know if it is serious about attacking the problem.

"You need to be able to say what proportion of patients are being seen," he says. "Even some mundane things are a struggle: How accurate is the PCP info in your system? Do you have a database of primary care docs so you can get appointments, and get paperwork to them?"

Another element that will be considered is integration between subspecialists and primary care providers, he says. If a patient goes to another specialist who orders tests or scans, how likely is it that that information is delivered to the primary physician? How long before it is put in the electronic record?

Baker says the added bonus for ensuring all this good communication is great patient satisfaction. He isn't sure of data to back it up, but he says whenever he was able to talk to patients with knowledge about something that happened at another physician's office without prompting, "they were always very pleasantly surprised. They would smile at the fact we actually talked to each other."

So many things about transitions are problematic, Baker concludes, and failures in these areas can lead to readmissions, worse health outcomes, even death. "For the best patient care, working as a good system is important to good patient outcomes. For an organization, this will help decrease readmission rates. And while I'm unsure about the literature support, I really think it will help with patient experience measures, too."

More information is available at http://www.jointcommission.org.

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The best catheter is one that's out

Protocol sets first call for removal in OR

Catheters cause urinary tract infections (UTIs) and the longer one is in place, the more likely it is to cause an infection. These infections aren't just painful to patients, either: They account for 40% of hospital-acquired conditions, for which CMS now penalizes hospitals. Avoiding them is high on the priority list of just about every hospital.

Now, researchers at Northwestern Memorial Hospital in Chicago have developed a protocol that aims to get catheters out of surgical patients as soon as possible — indeed, to keep them out of as many patients as possible to begin with. In its first five months, preliminary results are showing great success."

As a result of the protocol, the hospital has reduced the incidence of UTIs among surgical patients. The study authors presented their findings in July at the meeting of the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) Conference.

Using data from NSQIP, the group found that Northwestern initially had higher UTI rates than similar hospitals in the program — as high as two per month. After the program started at the beginning of this year, rates fell to an average of 0.4 per month, with two months where there were zero infections.

Data also showed that prior to the program, two-thirds of all surgical patients who had catheters may not have needed them since their surgeries took less than three hours, and only 22% of the catheters were removed right after the surgery was finished. In the months since the protocol was instituted, there has been a 12% decline in the use of catheterization of patients with short duration surgeries, and a 6% increase in the number of patients who had their catheters removed right after surgery ended.

The objective was to change clinical culture, says **Anthony Yang**, MD, FACS, author of the study and an assistant professor of surgical oncology in the Surgical Outcomes and Quality Improvement Center, Northwestern University Feinberg School of Medicine in Chicago. "Physicians tend to err on the conservative side and order catheters

routinely," he says. "We wanted them to think more critically about when to use catheters and weigh the need against the risk of infection."

The new protocol called for catheters in short cases only when there was an indication, for removal of catheters in theater or in the recovery room if at all possible, and for a two-person team to ensure that catheter placement adhered to all sterile techniques and guidelines, and the second person — the watcher — is to report any breaks in sterile procedure. If there is a break, a new catheter set is retrieved and they start again. Patients are instructed to void their bladders before surgery, as well.

Yang doesn't believe there will ever be zero UTIs, because there will never be zero catheters. However, the number can be reduced significantly. "If you don't have to put it in, don't; if you do, get it out."

He says that almost half the time, physicians forget that the patients even have a catheter in, which is why it's so important for that call to remove it to happen in the operating theater or recovery room. "If we don't do it there, then someone may forget."

The results have been gratifying, and much larger than Yang says he expected to see. "You put in an intervention, and you don't necessarily expect to see an immediate effect."

For more information on this topic, contact Anthony D. Yang, MD, FACS, Assistant professor of Surgical Oncology, Surgical Outcomes and Quality Improvement Center, Northwestern University Feinberg School of Medicine. Telephone: (312) 695-1419. ■

Magnet status improves outcomes

Mimic what you can for better patient care

Ask any nurse from a Magnet-recognized hospital if their facility is better than a non-Magnet counterpart and you'll get a quick yes. There are even some studies that seem to back up these strictly from-the-gut responses. But those previous studies have looked at Medicare discharges, neonatal patients, and surgical patients. None has examined patient outcomes at Magnet facilities — over 400 as of March 2015 — compared to others over time.

A new *Health Affairs* study has done just that and, for the first time, found that those facilities do, indeed, have lower mortality and failure-to-rescue rates than other hospitals.[1] Magnet hospitals subscribe to several key principles, including transformational leadership, empowering staff, and robust quality improvement mechanisms. More information is available at http://www.nursecredentialing.org/Magnet.

The study looked at nearly 1.9 million patients in almost 1,000 hospitals. Each Magnet facility was paired with two non-Magnet hospitals. The authors looked for 30 day all-cause mortality, as well as failure to rescue, which is defined as one of nine post-operative complications:

- Pulmonary failure
- Pneumonia
- Myocardial infarction
- Venous thromboembolism
- Acute renal failure
- Hemorrhage
- Surgical site infection
- Gastrointestinal bleed
- Reoperation[1]

The authors contend that failure to rescue is a good quality of care measure because it focuses less "on the occurrence of a complication and more on the hospital's capability to recognize and address a complication…[and] that, compared to complication rates, failure-to-rescue rates are more closely associated with differences in hospital characteristics."[1]

Most Magnet hospitals are larger than their counterparts, and better staffed with more registered nurses per patient day. They were more likely to have transplant programs and be teaching hospitals as well, but less likely to be urban.

The study found that 30-day mortality rates and failure-to-rescue rates were both significantly lower in Magnet facilities than in their matched controls. Patients in Magnet hospitals were 7.7% less likely to experience 30-day mortality (rates of 5.8% versus 6.3%), and Magnet patients were 8.6% less likely to die after a failure to rescue event.[1]

The authors didn't find that there was a significant improvement in hospitals after they became Magnet facilities, nor was there a big difference in the year before they gained that status.[1]

Failure to rescue, which the team used instead of looking at complications, has been studied since 1992, says **Christopher R.**

Friese, PhD, RN, AOCN, FAAN, lead author and an assistant professor at the University of Michigan School of Nursing's Department of Systems, Populations, and Leadership in Ann Arbor. "It's endorsed by the National Quality Forum and the premise is that since patients come to the hospital sick, we might not be able to prevent every single complication. However, if we examine patients who develop treatable complications, we can then determine if they died from the complication, or whether the hospital or provider rescued the patient from that complication."

Friese's own work, as well as that of two of his coauthors, **Jeffrey Silber**, MD, and **Amir Ghaferi**, MD, has demonstrated repeatedly that variations in failure-to-rescue rates are more attributable to differences in hospitals than anything else, while complications, on the other hand, are more attributable to patients' baseline frailty. This makes looking at that metric something valuable to do, and not just in terms of this study, but in general.

"To measure hospital quality, a lot of us prefer to use failure to rescue rather than surgical complication rates," he says, noting that there are big debates happening in some forums about the validity of surgical complication rates as a quality measure.

This doesn't mean that mortality and complication rates aren't good. But those are "low-hanging fruit" that payers are focusing on right now, he says. "If people think that these endorsed measures will factor into payer decision-making, they should try to identify how best to rescue patients after postoperative complications. Careful review of 30-day mortality after surgery is a good place to start. Why are patients dying? Can those complications be prevented? How can we need to redesign care to rapidly identify and treat complications?"

Friese acknowledges that not every hospital aspires to be, or can be, a Magnet hospital. It is a financial commitment, as well as one of time and manpower, just to go through the application process. "I think the message, though, is to keep looking for ways to improve quality," he says. "We don't have a magic bullet yet. Our study found that Magnet hospitals out-performed their peers, but Magnets were better before they were recognized and their performance didn't improve after they were recognized."

The fact that there was no post-status improvement in outcomes was a disappointment to him, he says. "Nurses who have participated in the recognition process often call it transformative for their nursing practice. Deep down, I had hoped we'd see further improvements in patient outcomes. It also appears that non-Magnet hospitals are catching up to their peers' outcome rates over the study's 13-year period. We'll have to see if that trend continues."

The authors are also interested in looking at how hospitals are able to detect complications before they become deadly, he says. "Are nurses and other providers empowered to alert doctors to worrisome signs and get the right resources in place to rescue patients successfully? Is it better ICU care? We're looking at this right now."

He says that if he was a leader in a struggling hospital, he would reach out to colleagues that had better outcomes and ask what's working where they are. "Michigan, we've seen remarkable results with the Blue Cross Blue Shield of Michigan-supported quality improvement collaboratives. Hospitals and doctors contribute outcomes data that are analyzed centrally — and confidentially — and best practices can be disseminated quickly. Researchers have shown this approach has reduced mortality and lowered costs in Michigan hospitals for general surgery."

In addition, the fact that hospitals were doing about the same before and after Magnet status means that there is something about them in and of themselves — something that perhaps makes that kind of hospital attempt and achieve Magnet status, he says. "We are recommending we take a look under the hoods of well-performing hospitals. Many of them are Magnets. Then we can learn what they're doing differently and share those lessons with struggling hospitals."

What is known about Magnets, Friese concludes, is that they are better places for nurses to work; they have less bureaucracy within the nursing department; they have better nurse staffing; and they hire more nurses with BSN degrees. "They perform benchmarking on key outcomes, like pressure ulcers and falls," he says, "and there is some evidence they are more cost-efficient. But we don't know the mechanisms that improve outcomes. And until we find that out, we're just guessing."

For more information on this topic, contact Christopher R. Friese, PhD, RN, AOCN, FAAN, Assistant Professor, University of Michigan School of Nursing, Department of Systems, Populations, and Leadership, Ann Arbor, MI. Email: cfriese@umich.edu

More information on what it takes to become a Magnet facility are available at http://www.nursecredentialing.org/Magnet

REFERENCE

1. Friese CR, Xia R, Ghaferi A, Birkmeyer JD, Banerjee M. Hospitals In 'Magnet' Program Show Better Patient Outcomes On Mortality Measures Compared To Non-'Magnet' Hospitals. *Health Aff* June 2015 vol. 34 no. 6 986-992 ■

Data from NSQIP better than others

Conference presentations show power of member metrics

Two studies released at the recent American College of Surgeons National Surgical Quality Improvement Program (NSQIP) conference show that data collected by the organization appears to be better than other sources of data for improving quality of care for surgical patients.

The first study, yet to be published as more than a conference abstract, came out of Inova Health System in Virginia, and looked at NSQIP data and administrative data used for billing. They looked at information from 157 readmissions at Inova Fairfax Hospital that had undergone general, endovascular, or colorectal surgery during 2013, and were readmitted within 30 days of their surgical procedures.

According to the study, their records were reviewed by three surgeons to determine the cause for their readmissions. They found the most common reasons were surgical site infections and intestinal obstruction.

The researchers, led by **Amber Trickey**, MSc, PhD, a surgery epidemiologist and biostatistician at Inova, then looked at the accuracy of administrative claims and the NSQIP data as compared to what the surgeons determined was the cause for those readmissions. The study found that there was a 71% agreement rate when using NSQIP data, but just 61% using administrative information. Trickey and her team also determined that about 60% of the readmissions were possibly preventable.

The authors noted in their work that one reason for the difference in the data might be a lack of specificity in the diagnosis codes in administrative data, compared to NSQIP data, which has very specific codes that can identify primary causes for readmission, and are standardized in ways that administrative data are not.

Next up, Trickey says she and her team will look further into those top two reasons for readmission — infection and obstruction — and see if there is anything they can learn that will help improve patient care further.

The second study presented at the conference used data from the National Inpatient Sample (NIS), the largest U.S. administrative database — which includes information on Medicare, Medicaid, the uninsured, and privately insured patients discharged from about 1,000 hospitals around the country — and compared it to NSQIP data on 11 major surgeries, including coronary artery bypass grafting, aortic valve replacement, and appendectomy. The other surgeries were abdominal aortic aneurysm repair, carotid endarterectomy, laparoscopic cholecystectomy, total and partial colectomy, esophagectomy, sleeve gastrectomy, pancreatectomy, and ventral hernia repair.[2]

The researchers, from UC San Diego, UC Davis, and Massachusetts General Hospital, looked at something called the c-statistic, a measure of model discrimination where a value of 1 indicates that the model is perfect in discrimination between cases that experienced and did not experience the adverse event, and a value of 0.5 indicates that discrimination is at the level of chance.[2]

When the researchers compared the c-statistic for complications and mortality models built from the two data sets, they found that they were consistently higher (closer to one) for ACS NSQIP data, compared with the NIS data. Unadjusted complication rates were higher in hospitals in the NIS for seven of the 11 surgeries, but unadjusted mortality rates in every procedure were lower in NSQIP hospitals. The authors concluded that those at the NSQIP hospitals seem to have lower inpatient mortality.[2]

For more information contact: http://www.acsnsqipconference.org/

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• *Anna Weiss, MD, Department of Surgery, University of California, San Diego. Email: a3weiss@ucsd.edu.*

REFERENCE

1. Weiss A, Anderson JE, Chang DC. Comparing the National Surgical Quality Improvement Program With the Nationwide Inpatient Sample Database. *JAMA Surg*. Published online June 10, 2015. doi:10.1001/jamasurg.2015.0962 ■

Journal outlines issues of contention in HAC program

Some changes may appease critics

Health Affairs is weighing in on the issue of the CMS program to reduce HACs through financial penalties of 1% this fiscal year. In an issue brief published August 6 on its website (http://bit.ly/1HtcBh0), author and Health Policy Consultant, Amanda Cassidy, outlines the background and some of the current debate about the program.

Among the items she cites as persistent problems are the overlap of measures. For example, she mentions that central line-associated bloodstream infections (CLABSI) are part of the healthcare-acquired conditions reduction program, but also part of Value-based Purchasing, which many feel is a double penalty.[1]

Another point of contention is that the law requires that hospitals be graded on a curve. That means that if everyone scores between the 90th and 100th percentile, those in the bottom will be penalized, even though they are, by definition, doing very well.

Others argue that using a composite measure, the claims-based PSI-90, isn't in keeping with the idea that all HACs be preventable. A composite isn't preventable. Only a specific condition is. The composite currently makes up the entirety of the first domain used in the HAC education program. That kind of measure also doesn't reflect patient complexity, critics say, and can include surveillance bias such that hospitals which are most vigilant about looking for problems end up finding more and are thus penalized more, and that those with larger volumes may pay more penalties than worse hospitals with small volumes that get to use national averages in their scores.

CMS says keeping the claims-based composite measure is important because the data come from "a widely available data source that produces minimal administrative and financial burden on hospitals." CMS has, though, reduced the weight assigned to PSI-90 from the original 50% and increased the number and weight of other measures.

Next up, the author says, 25% of hospitals will find out they will receive a penalty at the end of the summer/beginning of fall. However, in the future, CMS plans on increasing the number of measures a hospital can report and the number of measures from the National Health and Safety Network that were the counterweight to the PSI-90 composite in the second domain of the program metrics. Hospitals can also expand measures to other locations, like the intensive care unit or emergency department. These changes, the author says, mean a hospital that is penalized this year may find it easier to avoid penalty in the future.[1]

The PSI-90 composite itself may be in for a change, as the National Quality Forum is currently reviewing the components and weight, she says. Lastly, CMS is changing the way it will calculate the HAC total for 2017 that will give a maximum 10 as a value for hospitals for each NHSN measure that a hospital doesn't report.[1]

REFERENCE

1. Health Policy Brief: Medicare's Hospital-Acquired Condition Reduction Program. *Health Affairs*, August 6, 2015. ■

COMING IN FUTURE MONTHS

- What is "immediate jeopardy and how to avoid it.
- How the Mayo Clinic standardized care across 22 EDs in its system.
- Credentialing new tech skill set
- Arkansas hospitals are appealing a court ruling that weakens the peer-review protection of some information and puts it at risk of discovery in litigation. How could this impact you?

HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CNE QUESTIONS

1. Which of these is not part of the 8 point quality score devised by study authors?

a. 30 day readmission rates
b. Patient volume
c. Nurse ratio
d. Trauma center level

2. What is different about the two-midnight rule under the OPPS final rule?

a. It's now the 1 midnight rule
b. Physicians have discretion to call patients inpatient for short stays
c. Audits are suspended until January 1
d. Auditors aren't paid contingency fees

3. ERP used in colorectal surgery at UVA resulted in how much decline in complications?

a. 50%
b. 17%
c. 55%
d. 57%

4. The new integrated care certification looks at which kind of situations as part of its process?

a. 30-day readmissions
b. 30 day mortality rates
c. HAC rates
d. Transitions of care

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, health care workers, hospitals, or the health care industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

Hospital Peer Review

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. QI manager/director
- O B. outcomes management director
- O C. VP of quality assurance
- O D. nurse clinician
- O E. medical director
- O F. other _____

2. What is your highest degree?

- O A. associate or 2-year
- O B. diploma (3-year)
- O C. bachelor's degree
- O D. some graduate work
- O E. graduate degree
- O F. other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary healthcare position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to $89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban area
- O B. suburban area
- O C. medium-sized city
- O D. rural area

7. In the last year, how has your salary changed?

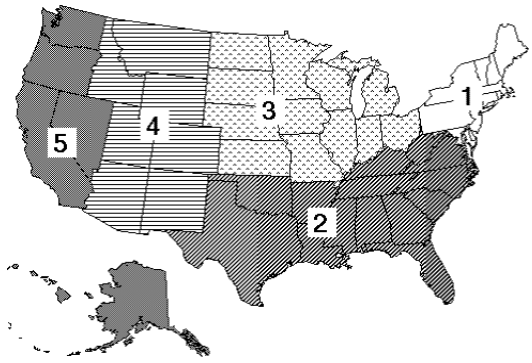
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

11. How long have you worked in quality?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

12. How long have you worked in healthcare?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

13. How many people do you supervise?

- O A. 0-3
- O B. 4-6
- O C. 7-10
- O D. 11-15
- O E. 16-20
- O F. 21-40
- O G. 41-60
- O H. 61-80
- O I. 81-100
- O J. 101+

14. How many hours a week do you work?

- O A. less than 20
- O B. 20-30
- O C. 31-40
- O D. 41-45
- O E. 46-50
- O F. 51-55
- O G. 56-60
- O H. 61-65
- O I. 65+

15. If you work in a hospital, what is its size?

- O A. <100 beds
- O B. 100 to 200 beds
- O C. 201 to 300 beds
- O D. 301 to 400 beds
- O E. 401 to 500 beds
- O F. 501 to 600 beds
- O G. 601 to 800 beds
- O H. 801 to 1,000 beds
- O I. >1,000 beds
- O J. I don't work in a hospital

Deadline for Responses: Nov. 2, 2015

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media LLC, P.O. Box 550669, Atlanta, GA 30355.