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DECEMBER 2015

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AHC Media

Hospital board, management closely tied to quality

Common wisdom has long held that quality healthcare begins at the top, with CEOs and hospital boards setting the right tone and expectations. Now that effect has been proven and quantified.

Quality leaders at hospitals should take the empirical evidence to the boardroom and the C-suite to impress on leadership how much they can influence the overall quality of care, suggests **Thomas Tsai**, MD, MPH, a surgeon and health policy researcher in the Department of Surgery at Brigham and Women's Hospital and in the Department of Health Policy and Management at Harvard School of Public Health in Boston. He also is currently serving as an adviser to the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services (HHS).

Tsai is the lead author on a study

in *Health Affairs* concluding that more effective management practices are associated with higher-quality hospitals, and that the effect can be measured. (*The study is available online at <http://tinyurl.com/pk4ocg4>.*)

In addition, the researchers identified two signatures of high-performing hospitals. First, hospitals with boards that had a high attention to quality had more effective management practices in monitoring. Second, hospitals with boards that effectively used

clinical quality metrics were more likely to have effective target setting and operations management practices.

"Hospitals performing above the median overall in the board performance index had a higher overall management score than those performing below the median (2.98 versus 2.70)," the report says. A one-standard-deviation increase in the board score was associated with a 0.297

"IN ADDITION, THE RESEARCHERS IDENTIFIED TWO SIGNATURES OF HIGH-PERFORMING HOSPITALS."

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Financial Disclosure: Editor Greg Freeman, Managing Editor Jill Drachenberg, Associate Managing Editor Dana Spector, and Nurse Planner Fameka Barron Leonard report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is author of by Health Administrative Press, and a stockholder of both General Electric and Johnson & Johnson.



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Hospital Peer Review®

ISSN 0149-2632, is published monthly by AHC Media, LLC

One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

GST registration number R128870672.

POSTMASTER: Send address changes to:

Hospital Peer Review®

P.O. Box 550669

Atlanta, GA 30355.

SUBSCRIBER INFORMATION:

Customer Service: (800) 688-2421.

CustomerService@AHCMedia.com.

AHCMedia.com

Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST

SUBSCRIPTION PRICES:

U.S.A., Print: 1 year: \$519. Add \$19.99 for shipping & handling.

Online only: 1 year (Single user): \$469

Outside U.S.A.: Add \$30 per year.

Total prepaid in U.S. funds.

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ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 1.25 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for *Hospital Peer Review*® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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standard deviation increase in the management score.

The research supports the trend to getting the hospital board more involved with improving quality metrics, Tsai says. Hospital boards, managers, and hospitals have been measured on quality metrics separately in past research, but this study combined them to determine how one affects the others.

“We found that all three were related to each other, such that high-quality hospitals with higher processes of care also had higher-quality board and management practices,” Tsai explains. “This suggests that it is important to maintain the quality of the board and management because the two of those are related to overall better care provided to patients.”

The researchers measured quality in four domains of management practice: operations, monitoring, targets, and human resources. Within each domain, specific criteria were measured. For instance, in the operations domain, a hospital would receive a low score if patient flow was not well thought out so that personnel and resources were utilized most efficiently and effectively. (*For examples of how the quality measures were scored, see the story on p. 130.*)

Tsai suggests that hospital boards and top management will welcome the data in his report.

“There is a realization that a hospital’s overall strategy needs to be aligned, that you can’t have physicians being measured on bloodstream

infections while the managers are incentivized to focus a different set of metrics, and the board focuses on another different set,” he says. “This research suggests that it is important to start aligning the way we think about quality along the entire spectrum of care — from the boardroom, to the C-suite, to management, to the nurses at the bedside.”

Tsai notes that one goal of the research was to create a taxonomy for measuring quality in management, similar to the specific quality metrics in clinical care.

The study’s confirmation of the board and management’s effect on quality could be a valuable tool for quality leaders trying to get more support and involvement from top leaders, says **Peggy Crabtree**, RN, vice president with The Camden Group in Los Angeles, who has more than 25 years of hospital leadership experience and held executive leadership roles in numerous hospitals.

Quality metrics should be embedded throughout the organization, Crabtree suggests, rather than limiting them to clinicians. Bonus structures should always include performance on quality metrics, she says, and job applicants should be asked how they influenced quality in previous positions.

Crabtree recalls working with a hospital to educate its board about quality and the board members’ role in improving quality. A year later, the chief nursing officer called to say the hospital had received several quality

EXECUTIVE SUMMARY

A hospital’s performance on clinical quality metrics is affected significantly by the board of directors and the facility’s management. Quality leaders should remind them of their influence and guide them to improving metrics.

- A recent study quantified the effect on overall quality.
- The board, management, and clinicians should be measured on the same metrics.
- Researchers are establishing a standard way to measure management quality.

awards and had significantly improved its performance on quality metrics.

“She thought it was because the board got behind them and really got engaged with what was going on,” Crabtree says. “I think we’re seeing that more and more now with bundling, value-based purchasing, and all the

other changes. Boards are getting more educated and involved because the financial pressure is making them realize their responsibility for oversight in quality.”

SOURCES

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Examples of high and low scoring in management study

The recent study in *Health Affairs* by **Thomas Tsai**, MD, MPH, a surgeon and health policy researcher in the Department of Surgery at Brigham and Women’s Hospital and in the Department of Health Policy and Management at Harvard School of Public Health in Boston, did not include examples of how the hospitals were scored on specific factors related to the board of directors and management. Tsai provided these examples of how two of the categories were measured, using a 1 score as the worst and a 5 score as the best:

OPERATIONS

1. Layout of patient flow

Score 1: Layout of hospital and organization of workplace is not conducive to patient flow (e.g. ward is on different level from theatre or consumables are often not available in the right place at the right time).

Score 3: Layout of hospital has been thought-through and optimized as far as possible; work place organization is not regularly challenged/changed (or vice versa).

Score 5: Hospital layout has been configured to optimize patient flow; workplace organization is challenged regularly and changed whenever needed.

2. Rationale for standardization and pathway management

Score 1: Changes were imposed top-down or because other departments were making (similar) changes; rationale was not communicated or understood.

Score 3: Changes were made because of financial pressure and the need to save money or as a (short-term) measure to achieve government and/or external targets.

Score 5: Changes were made to improve overall performance, both clinical and financial, with buy-in from all affected staff groups; the changes were communicated in a coherent ‘change story.’

3. Standardization and protocols

Score 1: Little standardization and few protocols exist (e.g. different clinical staff have different approaches to the same treatments).

Score 3: Protocols have been created, but are not commonly used because they are too complicated or not monitored adequately (e.g. may be on website or in manual only).

Score 5: Protocols are known and used by all clinical staff and regularly followed up on through some form of monitoring or oversight.

4. Good use of human resources

Score 1: Staff often end up undertaking tasks for which they are not qualified or over-qualified when

they could be used elsewhere; staff do not move across units, even when they are generally underutilized.

Score 3: Senior staff try to use the right staff for the right job, but do not go to great lengths to ensure this; staff may move but often in an uncoordinated manner.

Score 5: Staff recognize effective human resource deployment as a key issue and will go to some lengths to make it happen; shifting staff from less busy to busy areas is done routinely and in a coordinated manner, based on the documented skills.

MONITORING

1. Continuous improvement

Score 1: Process improvements are made only when problems occur, or only involve one staff group.

Score 3: Improvements are made in irregular meetings involving all staff groups, to improve performance in their area of work (e.g. ward or theatre).

Score 5: Exposing problems in a structured way is integral to an individuals’ responsibilities and resolution involves all staff groups, along the entire patient pathway; exposing and resolving problems is a part of a regular business process

rather than being the result of extraordinary efforts.

2. Performance tracking

Score 1: Measures tracked do not indicate directly if overall objectives are being met (only government targets are tracked); tracking is an ad-hoc process (certain processes aren't tracked at all).

Score 3: Most important performance or quality indicators are tracked formally; tracking is overseen by senior staff.

Score 5: Performance or quality indicators are continuously tracked and communicated against most critical measures, both formally and informally, to all staff using a range of visual management, too.

3. Performance review

Score 1: Performance is reviewed infrequently or in an un-meaningful way (e.g. only success or failure is noted).

Score 3: Performance is reviewed periodically with both successes and failures identified; results are communicated to senior staff; no clear follow-up plan is adopted.

Score 5: Performance is continually reviewed, based on the indicators tracked; all aspects are followed up on to ensure continuous improvement; results are communicated to all staff.

4. Performance dialogue

Score 1: The right information for a constructive discussion is often not present or the quality is too low; conversations focus overly on data that is not meaningful; a clear agenda is not known and purpose is not explicitly stated; next steps are not clearly defined.

Score 3: Review conversations are held with the appropriate data present; objectives of meetings are clear to all participating and a clear

agenda is present; conversations do not drive to the root causes of the problems; next steps are not well defined.

Score 5: Regular review/performance conversations focus on problem solving and addressing root causes; purpose, agenda and follow-up steps are clear to all; meetings are an opportunity for constructive feedback and coaching.

5. Consequence management

Score 1: Failure to achieve agreed objectives does not carry any consequences.

Score 3: Failure to achieve agreed results is tolerated for a period before action is taken.

Score 5: A failure to achieve agreed targets drives retraining in identified areas of weakness or moving individuals to where their skills are appropriate. ■

Better leadership, management leads to better quality

These are excerpts from the recent study in *Health Affairs* by **Thomas Tsai**, MD, MPH, a surgeon and health policy researcher in the Department of Surgery at Brigham and Women's Hospital and in the Department of Health Policy and Management at Harvard School of Public Health in Boston:

- “High-quality hospitals were more likely to have better management processes related to operations, monitoring, target setting, and human resources than low-quality hospitals. Management scores were significantly higher in hospitals with boards that paid greater attention to quality and that were more likely to adopt effective practices related to the use of data on clinical quality metrics. These findings suggest that board and management

practices are both strongly related to a hospital's performance on clinical quality metrics and may provide a unique target for quality improvement interventions reaching across multiple clinical domains.”

- “Our findings have important implications for policy as well as for health systems practice. Federal policy makers have signaled a commitment to accelerating the Affordable Care Act's (ACA's) transition to value-based payments by linking the majority of current Medicare fee-for-service reimbursements to quality in the next few years. This has the potential to create new impetus for organizational leaders to improve and ultimately deliver high-quality care. Given the relationship between board and management performance

with hospital performance on quality metrics, our findings suggest that there are other important tools that policy makers can use to drive improvements. For hospitals that are struggling with lower quality, encouraging board or management training (or both) might be useful.”

- “Given the recent increase in hospital consolidation, there is also concern that managerial focus has been directed toward expansion instead of internal improvement. Front-line staff and senior managers often have different perceptions of both the goals and results of quality improvement efforts, and the lack of a shared commitment and understanding by hospital leadership and staff may hinder the effectiveness of quality improvement initiatives.” ■

3M's PPR software criticized, but is research misleading?

The Potentially Preventable Readmissions (PPRs) from 3M fails at distinguishing differences in care quality, including key factors involved in readmission, according to a recent report. One of the physician developers at 3M, however, says the study was improperly designed and the negative conclusion is not correct.

The report suggests that the software fails to distinguish between readmissions that are preventable and those that aren't. The research was published online in *BMJ Quality and Safety* and an abstract is available online at <http://tinyurl.com/o2cp5bq>. Such a failure could be critical to hospitals because the PPRs are increasingly used to make payments to U.S. hospitals based on readmission rates, the authors wrote.

CMS posts data on 30-day readmissions for three common causes of hospital admissions: heart attack, heart failure, and pneumonia. Hospitals with high rates of readmissions are penalized financially and get less money from Medicare regardless of whether those readmissions could have been prevented.

In a bid to improve on the CMS measure and identify readmissions more likely to be preventable,

3M developed the PPRs measure, which is now increasingly used by U.S. state Medicaid programs for hospital payments. The 3M software identifies readmissions with diagnoses that are clinically related to those prompting the initial admission, to flag those patients whose readmission could have been avoided, and then generates hospital level rates of avoidable readmissions, taking account of population case mix and illness severity.

However, an unknown has been to what extent these pairings reflect quality of care problems and which readmissions are therefore truly preventable. Researchers led by Ann M. Borzecki, MD, assistant professor at the Boston University School of Public Health, Department of Health Policy and Management and the Boston University School of Medicine, looked at whether readmissions flagged as PPRs by 3M were associated with poorer quality of care than those that weren't. They focused on Veterans Health Administration patients admitted to hospital with pneumonia, and readmitted within 30 days, between 2006 and 2010.

They reviewed the medical records of 100 randomly selected cases out

of more than 11,000, to look at the quality of care these patients had been given while in hospital and after discharge, using processes of care derived from evidence-based data and a panel of clinical experts.

They were surprised to find that the quality of care among the 77 cases flagged as PPRs was slightly better than the 23 unflagged cases (total average scores of 71.2 vs. 65.8 out of 100), although this difference was not statistically significant.

They found little information about the quality of care after discharge for flagged and unflagged cases.

Their findings lead the researchers to conclude that either PPR flagged cases are not more preventable, or that assessment of preventability requires other data collection methods to capture poorly documented processes.

"Among VA pneumonia readmissions, PPR categorisation did not produce the expected quality of care findings," the researchers concluded. "Either PPR—yes cases are not more preventable, or preventability assessment requires other data collection methods to capture poorly documented processes (e.g., direct observation)."

3M submitted a response to *BMJ Quality and Safety* but has not learned whether the journal will publish it.

Norbert Goldfield, MD, medical director for 3M Health Information Systems and one of the principal designers of the PPR classification methodology, provided a copy of the letter to *Hospital Peer Review* and elaborated on 3M's concerns about the study. (For excerpts from the 3M letter, see the story on p. 126.)

EXECUTIVE SUMMARY

New research suggests that a popular 3M software program doesn't clearly distinguish differences in care quality. The issue is important because the program is increasingly used to make payments to U.S. hospitals based on readmission rates.

- 3M says the study is flawed and the conclusion incorrect.
- The researchers concluded that either PPR flagged cases are not more preventable, or additional data collection is needed.
- The findings are based on a review of 100 randomly selected cases.

The letter begins by saying, “Unfortunately, the design of the study was based on a misinterpretation of the meaning of the PPR categorization as well as its intended use.”

The report was troubling to some quality leaders. In a linked editorial, physicians from Mount Sinai Hospital in Toronto, Canada, suggest that, “After years of intensive research to find an objective measure of preventable readmissions, it seems as imminent as the arrival of Godot.” Perhaps readmission rates are too crude a measure and aren’t patient-centered in the way some calculations assume, says one of the editorial authors, **Christine Soong**, MD, MSc, CCFP, assistant professor at the University of Toronto and director of the Hospital Medicine Program at Mount Sinai Hospital and University Health Network in Toronto. (*The editorial is available online at <http://tinyurl.com/plq4fno>.*)

This latest research confirms

that there is no “magic bullet” for identifying preventable readmissions, Soong tells *Hospital Peer Review*. She suggests that quality officers using the 3M software use caution in interpreting the data and not assume that the identification of preventable readmissions is correct or complete.

“The study suggests that the 3M tool is not sensitive enough to capture preventable readmissions, and if anything, it looked like some deemed non-preventable had better quality measures than those that may have been preventable,” she says. “Basically it’s telling us that we’re no further ahead in being able to identify readmissions that were preventable.”

As for 3M’s contention that the study was designed incorrectly, Soong notes that there is evidence suggesting that software systems using administrative data to calculate preventable readmissions fail to consider other important unmeasured factors that contribute to readmissions. Research suggests

that hospitals with high “risk adjusted” rates of PPRs differed in many patient characteristics not included in the risk adjustments but which accounted for approximately 50% of the observed differences in probability of readmission.

“In other words, risk adjustment calculators such as those of 3M do not account for many patient factors that contribute to readmission, such as socioeconomic status, education, and functional status,” Soong says.

SOURCES

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Study design misinterprets categories, 3M says

3M, the maker of the Potentially Preventable Readmissions (PPRs) software, responded to recent criticism that it fails at distinguishing differences in care quality by submitting a letter to *BMJ Quality and Safety*, which published the study. The following are excerpts from the letter:

- “Given that the study design examined the rate of quality problems for patients with PPRs compared to patients with non-PPRs, no meaningful conclusion can be drawn from the study results. The correct study design would have been to examine the rate of quality problems for pneumonia patients with a readmission

categorized as a PPR compared to pneumonia patients who were not readmitted. There is a reasonable expectation that pneumonia patients who were not readmitted would have fewer quality problems than pneumonia patients with a readmission categorized as a PPR.”

- “In order to be consistent with the definition of PPRs and the intended use of PPRs, the most meaningful study design would have examined the rate of quality problems for pneumonia patients with a PPR who were treated in hospitals with a high risk-adjusted PPR rate compared to pneumonia patients who were not readmitted.”

- “Judgment on the ultimate

efficacy and utility of PPRs should be based on whether PPRs identify patients for whom quality improvement is realistically possible and whether PPR-based data can be used to actually achieve lower readmission rates. For example, between 2011 and 2013 the PPR-based “Reducing Avoidable Readmissions Effectively” (RARE) Program in Minnesota reduced readmissions by over 20 percent by preventing 7,975 readmissions, thus avoiding more than 31,900 bed days. (MHA, 2015) Such reductions demonstrate that PPR-based data is effective in fostering real behavior change that leads to lower readmission rates.” ■

Complications initiative saves \$120 million, improves quality

A three-year initiative by New Jersey hospitals to confront and reduce the incidence of complications for hospitalized patients is reporting positive results: more than 13,730 cases of patient harm averted and \$120 million in healthcare cost savings. Other hospitals across the country could replicate the same results, participants say.

The initiative, Partnership for Patients-New Jersey, was part of the national Partnership for Patients project, spearheaded by the U.S. Centers for Medicare & Medicaid Services and involving hospitals across the country. In New Jersey, the effort was led by the New Jersey Hospital Association's (NJHA) Institute for Quality and Patient Safety, which was designated as one of 27 "hospital engagement networks" nationwide.

NJHA has been selected as one of 17 national, regional or state hospital associations and health system organizations to continue efforts in reducing preventable hospital-acquired conditions and readmissions. Through the Partnership for Patients nationwide public-private collaboration, which began in 2011 to reduce preventable hospital-acquired conditions by 40% and 30-day readmissions by 20%, NJHA will participate in a second round of hospital engagement networks to continue working to improve patient care in the hospital setting.

Since the launch of the Partnership for Patients, the vast majority of U.S. hospitals and many other stakeholders have joined the collaborative effort and delivered results. The Department of Health and Human Services has estimated that 50,000 fewer patients died in

hospitals and approximately \$12 billion in healthcare costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. Nationally, patient safety is improving, resulting in 1.3 million adverse events and infections avoided in hospitals since in that time period. This translates to a 17% decline in hospital-acquired conditions over the three-year period.

In New Jersey, NJHA worked with the state's hospitals from 2012 through 2014 in a program that focused on education from national experts, sharing of best practices, and detailed data reporting to achieve better, safer healthcare services for patients.

The hospitals focused on reducing adverse events in 10 areas, explains **Aline Holmes**, RN, DNP, NJHA's senior vice president of clinical affairs and director of NJHA's Quality Institute. Those areas were four different kinds of infections plus surgical infections, falls, pressure ulcers, adverse drug events, adverse obstetric events, and readmissions.

New Jersey hospitals had been addressing some of those issues in smaller projects before the Partnership for Patients project, so they were able to build on that success, Holmes notes. Hospitals in the state had previously addressed cesarean section rates and early elective deliveries, for instance. The early elective rate dropped from 6% to 1% over the course of the current project, Holmes notes.

Holmes explains that the New Jersey results are attributable mostly to reduced rates in post-surgical infections, pressure ulcers or medication errors. New Jersey hospitals posted a 27.1% average reduction in these conditions in 2014.

They also achieved a 7.7% decrease in the rate of patients readmitted to the hospital within 30 days of a prior hospital stay. (*For detailed results in New Jersey, see the story on p. 129.*)

By comparing those new rates against the industry's standard expected rates, this work has averted a case of medical harm for 13,730 New Jersey patients by the end of the three-year initiative, Ryan says. Those averted complications saved the healthcare system about \$120 million in added costs, according to cost data from the U.S. Agency for Healthcare Research and Quality (AHRQ). The largest cost savings come from the reduction in hospital readmissions, which accounts for about \$84 million of the projected savings.

Reduced cost for the healthcare system is "icing on the cake," says NJHA President and CEO Betsy Ryan, Esq. Improving patient care is always the primary goal, she says, with the added bonus that avoiding adverse events almost always means avoiding extra expenses.

NJHA used a variety of methods to help hospitals address the targeted adverse events, Holmes says. Speakers were brought in to hospitals for seminars, and the association also hosted monthly webinars and conference calls. The webinars and conference calls were useful in presenting new content, coaching, and hearing updates on the hospitals' progress, as well as reports of problems or challenges encountered.

Those virtual meetings also allowed hospitals to share information and develop best practices.

"When we started out, everyone had a different process for pressure ulcers and that was problematic, but over the

course of a couple years they came to consensus on standardizing the process. They could see how important it was to be consistent, with these patients going back and forth across care settings,” Holmes says. “One of the best things was that even when the hospitals were very competitive, the physicians weren’t and they were willing to cooperate and exchange information.”

NJHA also set up listservs so that a nurse, for example, could post a question about the project’s goals and receive multiple responses within an hour. That was a more attractive option to many participants than contacting NJHA or hospital administration, Holmes notes, and in many cases the project’s experts in a particular topic participated on the listservs.

Ryan points out that physician engagement is critical for making a project like this successful. Also, she says it is important not to alienate clinicians by making dramatic changes in policies and procedures overnight. The better approach is to determine what changes need to be made to get to the goal, but then implement them incrementally.

“We learned early that making wholesale changes created a lot resistance from physicians, who all thought that you were saying that what they had

EXECUTIVE SUMMARY:

A New Jersey initiative to reduce complications for hospitalized patients is reporting significant success. Over three years the program averted almost 14,000 incidents of patient harm and saved \$120 million in healthcare costs.

- New Jersey hospitals achieved a 7.7% decrease in the rate of patients readmitted to the hospital within 30 days of a prior hospital stay.
- Reduced readmissions account for about \$84 million of the projected savings.
- New Jersey has traditionally had one of the nation’s highest rates of readmission.

been doing along was wrong,” Ryan says. “Try small things rapidly, measure the effects, and then spread those.”

The initiative is not just about statistics and dollars, Holmes notes. “This work has a very real impact on patients,” she says. “It means better care, shorter hospital stays, and better patient outcomes. I’m especially proud of the areas like surgical site infection rates and birth issues like early elective deliveries, where New Jersey hospitals not only have improved their results over time, but have also performed much better than the national average.”

Thirty-day readmission rates are another key issue for New Jersey, Holmes says. The state has traditionally had one of the nation’s highest rates of readmission, and now research has shown that socioeconomic factors make it more difficult for states like New Jersey,

with many urban communities, to reduce hospital readmissions.

“There are numerous personal economic factors that affect whether a patient may return to the hospital after an initial stay, such as whether a patient can afford prescriptions or whether transportation is available for follow-up appointments,” Holmes says. “But the good news is that New Jersey hospitals are making progress, and our work on readmissions alone has resulted in \$84 million in reduced healthcare costs in our state.”

SOURCES

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AHA pushing CMS to improve Hospital Quality Star Ratings

The American Hospital Association in Washington, DC, is sending a stern message to the CMS: Your Hospital Quality Star Rating System isn’t working so well.

AHA Acting Senior Executive for Policy **Ashley Thompson** recently sent CMS a letter saying the Star Rating system must be improved to make the ratings more credible and relevant to improving the patient

experience. She notes that hospitals were instrumental in the creation of Hospital Compare more than a decade ago, and she says they remain committed to sharing meaningful, accurate hospital quality information.

The Star Ratings don’t do that, Thompson claimed. “These ratings are intended to drive patients to wise choices about where they seek care. Thus, CMS has an obligation to ensure

the differences in ratings it portrays are real, meaningful and important to patient outcomes,” she wrote.

“Users and hospitals have a reasonable expectation that, if CMS is going to assign Star Ratings to hospitals for the purpose of identifying different levels of performance, CMS will be able to substantiate its assertion that a three star hospital is more likely to deliver care patients would find superior to that

These are some detailed results of the three-year initiative by Partnership for Patients-New Jersey, part of the national Partnership for Patients project and launched by the CMS:

- Adverse drug events declined from 10.4% to 6.5%, a reduction of 37.9%.
- Catheter-associated urinary tract infections declined from a rate of 2.27 per thousand catheter days to 1.72, a reduction of 24.1%.
- Central line-associated bloodstream infections declined from a rate of 1.40 infections per 1,000 central line days to 1.07, a reduction of 23.5%.
- Patient falls declined from

3.1 per 1,000 patients to 2.76, a reduction of 11.1%.

- Early elective deliveries declined from 2.9% to 0.9%, a reduction of 69.9%.
- Birth trauma injuries declined from a rate of 2.3 per 1,000 live births to 1.90, a 19.8% reduction.
- Obstetric trauma declined from a rate of 148.5 per 1,000 (with a medical instrument) and from 24.5 per 1,000 (without instrument.) The rate reduction is 33% and 27.1%, respectively.
- Pressure ulcers declined from a rate of 1.79 per 1,000 to 1.39 per 1,000, a reduction of 27.1%.
- Surgical site infections following

colon surgery declined from 4.34% to 2.01%, a reduction of 53.6%.

- Surgical site infections following hysterectomy declined from 1.47% to 1.32%, a reduction of 9.9%.
- Surgical site infections following total knee replacement declined from 1.03% to 0.29%, a reduction of 71.9%.
- Venous thromboembolism (blood clots) declined from 0.73% to 0.62%, a reduction of 14.1%.
- Hospital readmissions within 30 days declined from 21.4% to 19.8%, a 7.7% reduction.

The full report on New Jersey's Year 3 results can be found at <http://bit.ly/1XLXomn>. ■

delivered at a one- or two-star hospital, and less likely to deliver superior care than a four- or five-star hospital.”

The AHA head noted that her group had warned CMS of the difficulty in devising a star rating that would “equip patients, families and communities with a meaningful, accurate picture of hospital quality that is relevant to their individual reasons for seeking care.” Lacking confidence that CMS could use the measures available on Hospital Compare to create a comprehensive star rating, AHA urged CMS to apply Star Ratings only to specific measure topics, like cardiac care, rather than one overall rating for each hospital.

As it turned out, CMS developed a star rating that does apply mostly to specific measures, but then touted the ratings as a measure of the hospital's overall quality, Thompson explained.

Some validity to AHA concerns

It's hard to argue with substantial sections of the AHA's critique, says **Frank Ingari**, CEO of NaviNet,

a Boston, MA-based healthcare collaboration network connecting more than 40 health plans and 60% of the nation's physicians.

“Overall, the methodological analysis deserves a thoughtful response, since it suggests that CMS' proposed approach may not be optimal scientifically, may promote confusing or even misleading impressions among consumers, and will appear to function as a ‘black box,’” Ingari says. “Most important is the AHA's request for a more direct line of sight between measured performance and performance improvement actions. After all, this has been the principal power of the Medicare Advantage Star Rating system - payers have well defined paths (however challenging) that they can follow to improve their scores.”

The ratings process should have begun by identifying a small set of scientifically sound measures for critical aspects of care and which consumers find compelling, Thompson explained in the letter. Instead, CMS uses some measures — such as readmission measures — that

were created to meet specific legislated program needs, and some created for research and registry purposes. The measures also focus on factors that affect only some patients, such as heart attack, stroke or pneumonia. Few of the CMS measures involve cross-cutting issues affecting many patients, Thompson noted.

“The measures themselves range from patients' assessments of the cleanliness and quiet of the inpatient care facility, to measures of key outcomes that apply only to Medicare fee-for-service patients with particular conditions, to measures of how efficient hospitals were in providing certain imaging services in the outpatient setting,” she wrote. “It is not clear to what extent, if any, these are the measures that would be most relevant to patients or other users if they were to describe what they would want to be incorporated into a star rating system of hospitals.”

Thompson cited research showing that the readmissions measures CMS uses cannot be used to compare the performance of one hospital to another. Rather, the only valid comparison

is between each hospital and a hypothetical average hospital, she noted.

“Thus, we believe it is not possible to accurately assign star ratings to hospitals based on these non-comparable performance measures. The measures are simply not constructed in a way to permit this kind of hospital-to-hospital comparison,” she wrote. “We urge CMS to reconsider using readmission and mortality measures in the star rating system since they will likely lead to the misclassification of hospitals, resulting in misinformation for patients.”

AHA also isn't happy with CMS plans to group existing measures into seven categories — mortality outcomes, safety outcomes, readmissions outcomes, patient experience, timeliness of care, effectiveness of care and imaging efficiency — and apply a latent variable model to each group. The latent variable model holds that a single common factor is present for the measured performance of a hospital on

each of the measures in a group, and that factor could be described as the hospital's influence on the measured performance. CMS would calculate the value of the “latent variable” and then use that as the measure of how a hospital performed on each category, which dictate how many stars are awarded to the hospital.

That proposal may delight statisticians, Thompson wrote, but it won't yield accurate quality ratings. “We urge CMS to take a step back and consider something simpler and with a more direct ‘line of sight’ between measured performance and performance improvement actions,” she said.

Even if the program can be improved, Ingari says Medicare Advantage Star Ratings are the most potent proven reform driver in the healthcare system, Ingari says. Using well-defined metrics widely approved by the clinical and

payer communities, and powered by significant financial rewards and punishments, the Star Ratings have given CMS a vehicle to reshape U.S. healthcare by effectively “moving the goalposts” a few yards every year.

“The AHA letter can be read, in some ways, as a plea to see that hospital star performers have the same characteristics, including the more gradual introduction that CMS used with the MA Stars program years ago,” he says. “I would like to see the MA Stars program used as the centerpiece of value-based measurement programs in Managed Medicaid, Exchanges, and Hospital Compare. It can always be improved, but is proven, flexible, and effective.”

The AHA letter is available online at <http://tinyurl.com/neucjz>.

SOURCE

Frank Ingari, CEO, NaviNet, Boston, MA. Telephone: (617) 715-6000. ■

Fewer hospitals get five-star ratings

The five-star rating on the CMS Hospital Compare website is becoming a more exclusive club. This year, CMS awarded 207 hospitals a five-star rating, down from 336 in its most recent posting.

The two-star rating went to 638 hospitals and 76 got only one star.

CMS bases its Star Ratings on the 11 publicly reported measures

in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which assesses patient experiences. CMS updates the ratings every quarter, and the latest results are for the reporting period from Jan. 1, 2014, through Dec. 31, 2014.

The 207 five-star ratings represent 6% of the 3,539 eligible hospitals,

a worse showing than the July 2015 update when 336 of the 3,548 eligible hospitals achieved the highest level. In addition 1,087 (31%) received four stars; 1,531 (43%) received three stars, 638 (18%) received two stars, and 76 (2%) received one star.

There were 1,092 hospitals that could not be rated because CMS had insufficient data. ■

GAO says quality incentives, penalties not improving quality

Neither bonuses nor penalties are having much of an effect on improving the quality of care in hospitals, according to a report from the U.S. Government Accountability Office (GAO).

The government investigators found that the bonuses and penalties received by most of the approximately 3,000 hospitals eligible for the Hospital Value-based Purchasing (HVBP) program amounted to less than 0.5% of

applicable Medicare payments each year. Safety net hospitals, those providing a significant amount of care to the poor, consistently had smaller bonuses or penalties than hospitals overall.

“Small urban hospitals had higher

median payment adjustments each year than hospitals overall, and small rural hospitals' median payment adjustments were similar to hospitals overall in the first two years and higher in the most recent year," the investigators reported.

Most importantly, the GAO analysis found little effect on quality. There was no apparent shift in existing trends in hospitals' performance on the quality measures

included in the HVBP program, they reported. They note, however that quality could improve as the HVBP program continues to evolve.

"For example, new quality measures will be added, and the weight placed on clinical process measures — on which hospitals had little room for improvement — will be substantially reduced," the report notes. "For many quality measures

not included in the HVBP program, GAO also found that trends in hospitals' performance remained unchanged in the period GAO reviewed, but there were exceptions in the case of three measures that are part of a separate incentive program targeting hospital readmissions."

The full report is available online at <http://www.gao.gov/products/GAO-16-9>. ■

Wearable ventilator said to improve health, save money

New data presented recently indicate that use of a wearable ventilator system in COPD patients is associated with significant improvement in healthcare utilization and overall respiratory health status.

Study findings were released at the annual American College of Chest Physicians (CHEST 2015) meeting in Montreal, Canada. The data were presented by Neil MacIntyre, MD, FAARC, a pulmonologist at Duke University Medical Center in Durham, NC, and included an economic analysis.

Patients with chronic respiratory insufficiency frequently suffer from exacerbations, resulting in increased physician office visits, time in the emergency room, and hospital admissions, MacIntyre noted.

"The data analyzed in this study further reinforce current clinical evidence that wearable ventilator technology can improve healthcare utilization measures across a wide spectrum of parameters, help patients with chronic respiratory disease better manage their conditions, and have the potential to significantly decrease healthcare expenditures," he reported at the conference.

The study evaluated 16 stable

oxygen-dependent patients with moderate to very severe COPD who were using a one-pound wearable system as a complement to their standard medical care regimen. In addition to statistically significant health care utilization across four of five healthcare utilization measures (emergency room visits, hospital days, hospital ICU days and mechanical ventilations), researchers estimated total cost reductions across the study

population of between 68% and 96%. Office visits were the only measure that did not achieve significant decreases in frequency or cost.

Additionally, results from two validated patient reported measures of respiratory status were collected. COPD Assessment Test (CAT) and modified Medical Research Council (mMRC) scores improved significantly in the post-NIOV implementation period. ■

CORRECTION: An article in the November issue of *HPR* stated that the *Mallick v. Brink* case ruled that sentinel event reports to TJC are privileged in Pennsylvania. However, the defendant filed a motion to reconsider, and the court granted the motion in June, reversing the decision and ruling the reports are not privileged and must be product in litigation. ■

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CNE QUESTIONS

1. What was a main conclusion of Thomas Tsai, MD, MPH's research?

- A. A hospital's board and management have a significant effect on quality.
- B. A hospital's board has a significant effect on quality, but not management.
- C. A hospital's management has a significant effect on quality, but not the board.
- D. Neither the hospital's board nor management have a significant effect on quality.

2. What does a recent study in *BMJ Quality & Safety* claim is a problem with the Potentially Preventable Readmissions software from 3M?

- A. It is incompatible with too many hospital systems.
- B. It does not take regional differences into account when analyzing readmissions.
- C. It is outdated.
- D. It fails at distinguishing differences in care quality, including key factors involved in readmission.

3. What were the results of a three-year initiative by New Jersey hospitals to confront and reduce the incidence of complications for hospitalized patients?

- A. More than 13,730 cases of patient harm averted and \$120 million in healthcare cost savings.
- B. More than 6,549 cases of patient harm averted and \$150 million in healthcare savings.
- C. More than 13,730 cases of patient harm averted but no significant effect on healthcare savings.
- D. More than 6,549 cases of patient harm averted but no significant effect on healthcare savings.

4. What does the AHA allege is the key problem with the Hospital Star Ratings system?

- A. Too many hospitals are left out of the ratings.
- B. CMS developed a star rating that applies mostly to specific measures but then touted the ratings as a measure of the hospital's overall quality.
- C. CMS developed a star rating that is primarily about saving money when the focus should be on patient care and quality.
- D. So many hospitals are included that the ratings have little meaning.

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